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Proceedings

EMERGENCY CONTRACEPTION WORKSHOP

December 9-10, 1997

Dhaka, Bangladesh

Population Council, **Bangladesh**
House CES (B) 21, Road 118, Gulshan, Dhaka

Population Council is an international non-profit organization established in 1952, seeks to improve the well being and reproductive health of current and future generations around the world and to help achieve a humane, equitable and sustainable balance between people and resources.

The Council analyzes population issues and trends; conducts research in the reproductive sciences; develops new contraceptives; works with public and private agencies to improve the quality and out reach of family planning and reproductive health services; helps government design and implement effective population policies; communicates the results of research in the population filed to diverse audience; helps strengthen professional resources in developing countries through collaborative research and program, technical assistance, awards, and fellowships.

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PROCEEDINGS

EMERGENCY CONTRACEPTION WORKSHOP

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Organized by:
Population Council
Concerned Women for Family Planning
Dhaka, Bangladesh

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INTRODUCTION


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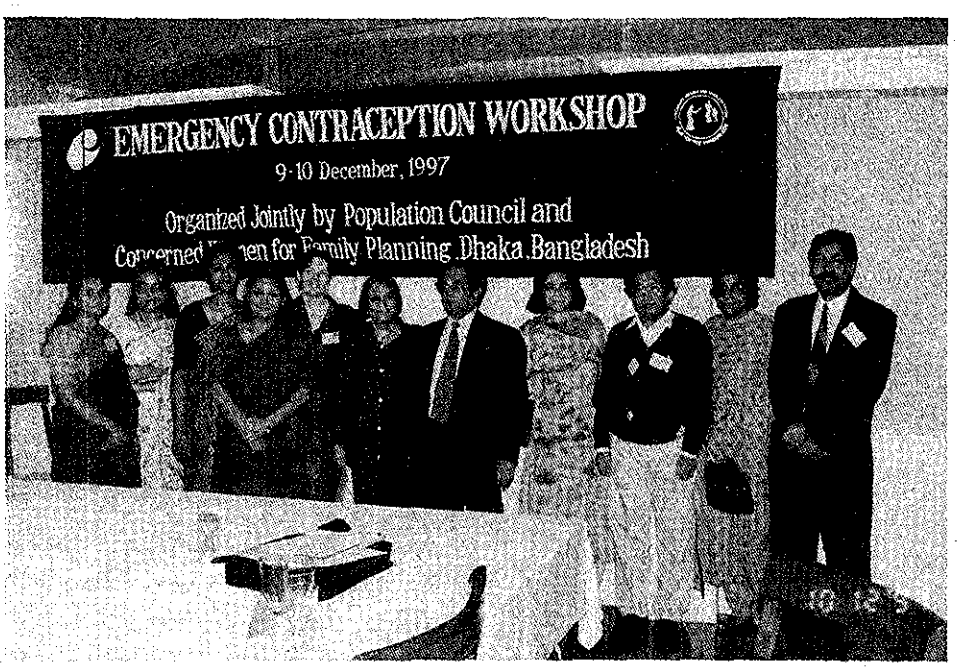
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1.1 WHY THE WORKSHOP?

Emergency contraception (EC) occupies a unique position in the range of family planning methods currently available to women. ECs enable women to prevent pregnancies after they have an unprotected sex. Thus it averts unplanned and unintended pregnancies, which in turn, reduces unsafe abortion women often resort to for unwanted pregnancies. Emergency contraception therefore is an element of reproductive health care which enhances reproductive choice for women in a situation where women may have little control over their sexual lives.

In Bangladesh emergency contraception has not yet made abode in the national family planning program. Although a number of methods that are currently available in the system can be used as emergency contraception, where all that is needed is to prescribe the methods in altered doses. However, general lack of knowledge of the providers and lack of a clearly defined policy is possibly the reason why this method was not promoted. Only recently a brand of pill named **"Postinor"** is available in the private sector but very little is known about its acceptability, utilization pattern as well as providers perception regarding the method.

It may be notable that more than half of the currently married women in Bangladesh are not using any method (BDHS 1996-97, Preliminary Report) and nearly 40 percent of the contraceptive users stop using contraception within 12 months of starting, due to side effects and method failure. Also, much alarming as it may seem, approximately 730,000 abortions are estimated to occur each year in Bangladesh. Statistics also show that about 52,000 women are treated in the hospitals annually for abortion complications of induced abortion and another 19,000 are treated for complications resulting from Menstrual Regulation procedures (Singh et. Al., 1997). Availability of emergency contraception can reduce the need for abortion services which are often more costly, poor in quality, sometimes enhancing risk of RTIs and HIV and even forge life threatening conditions.

Therefore in Bangladesh there is an urgent need to sensitize the policy makers, program managers, service providers and researchers regarding emergency contraception and its acceptance in the national FP program.

1.2 OBJECTIVES OF THE WORKSHOP

- To provide information about the experiences with emergency contraception in Bangladesh and neighboring countries
- To identify scope of emergency contraception in the national program
- To formulate plan for future research and actions on emergency contraception
- To develop a network of organizations for formulating programs on emergency contraception

1.3 PARTICIPANTS

A total of 65 participants attended the workshop. These participants were selected from GoB, NGOs as well as international organizations and included program planners, policy makers, donors, women activists, pharmaceutical representatives, researchers, service providers, program managers and media personnel. Selection of participants were based on their ability to advocate the issue at

the policy making level and on the aptness to promote emergency contraception into the current FP-MCH program.

1.4 WORKSHOP IMPLEMENTATION STRATEGY

The workshop was held in Dhaka from December 9 to December 10, 1997. A total of eleven papers were presented addressing different aspects of emergency contraception followed by group discussions and plenary. The learned presenters were selected from the field of reproductive health research, advocacy and family planning programs as well as the mass media. Besides, the guests and session chairs were from the GoB family planning and health sector and successful NGO program executives.

The workshop was conducted in collaboration with an NGO 'Concerned Women for Family Planning' (CWFP). CWFP is one of the largest family planning NGO working with women. It has an extensive network of service delivery out lets as well as door step service delivery system. Besides, CWFP has a well developed training and operations research unit and is a member of various policy level forays and bodies. This collaboration will enable Population Council to establish partner ship with community based organizations and build platform for future research in this area.

1.5 OUTCOME OF THE WORKSHOP

The meeting on emergency contraception drew the country's most prominent family planning managers, donors, policy makers, researchers and women's health advocates together along with internationally acclaimed technical experts and health advocates to learn about emergency contraception and discuss the possible scope of such methods in Bangladesh.

The workshop, being one of the very first of it's kind in the country, ended in a remarkable note of consensus. All the participants agreed that the method is suitable for introduction and very much needed in the present family planning program. Participants felt that the Yuzpe regimen, Levonorgestrel and, to a limited extent Cu-T regimen should be made available to women as an emergency option. However all participants unanimously agreed on the need for training of the providers and the production of effective IEC to raise awareness of the clients not only on emergency contraception but also reproductive functions. The role of media in this regard was widely explored.

In order to continue dialogue on this topic the Council floated the idea of a forum on emergency contraception, which was supported by almost all participants. The most promising note of the workshop was that the government representatives as well as representatives of the National Technical Advisory Committee agreed to raise the issue in the National Technical Advisory Committee meeting to be held on the following day, and emphasized the need for a task force on emergency contraception. At the National Technical Advisory Committee meeting all members agreed in principle that **'Emergency Contraception'** should be made available as a backup family planning option. The committee also recommended development of a proposal on it's inclusion in the national family planning program. Dr. Halida H. Akhter, Director, Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (BIRPERHT) has been given the responsibility to develop the proposal.

SPEECHES


Concerned Women for Family

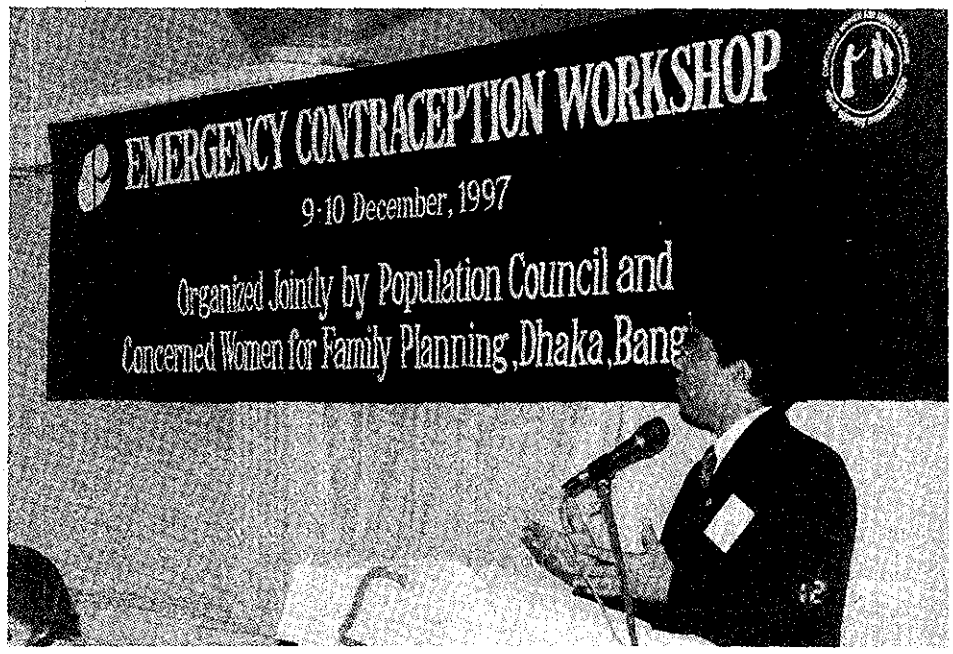
2.1

Mr. Md. Nurul Abedin

SECRETARY
MINISTRY OF SOCIAL WELFARE

Bangladesh, being one of the most densely populated countries in the world, surely deserves attention as an imminent member of the developing countries currently concerned with population and development. During the past decade, our country has shown commensurated interested and capability in various family planning programs and projects. Perceiving the importance, the government of Bangladesh has planned and implemented programs with success and extremely positive results in such a sensitive sector has fabricated this country to the world's concern.

But as cherishable as it may seem, we still have a long way to go since the manifestation of more modern methods have upgraded people's choice of contraception. For the last couple of days, this workshop on Emergency Contraception quite definitely mirrors the various aspects evolving these methods. In all the sessions, there has been a most productive exchange of views and conceptions, which includes the efficacy and global picture of Emergency Contraception, the need for advocacy and media, the experiences of South Asia, the role of males in such a subject, the scope of it in Bangladesh and the experiences from grassroots levels. The three group discussions highlight the viable choice, service delivery issues and advocacy and IEC. This sort of gathering is surely a boost to the implementation of emergency contraception issues, currently scarce in the scene of family planning. I sincerely wish all the best for a fruitful attainment in the future planning and program implementation.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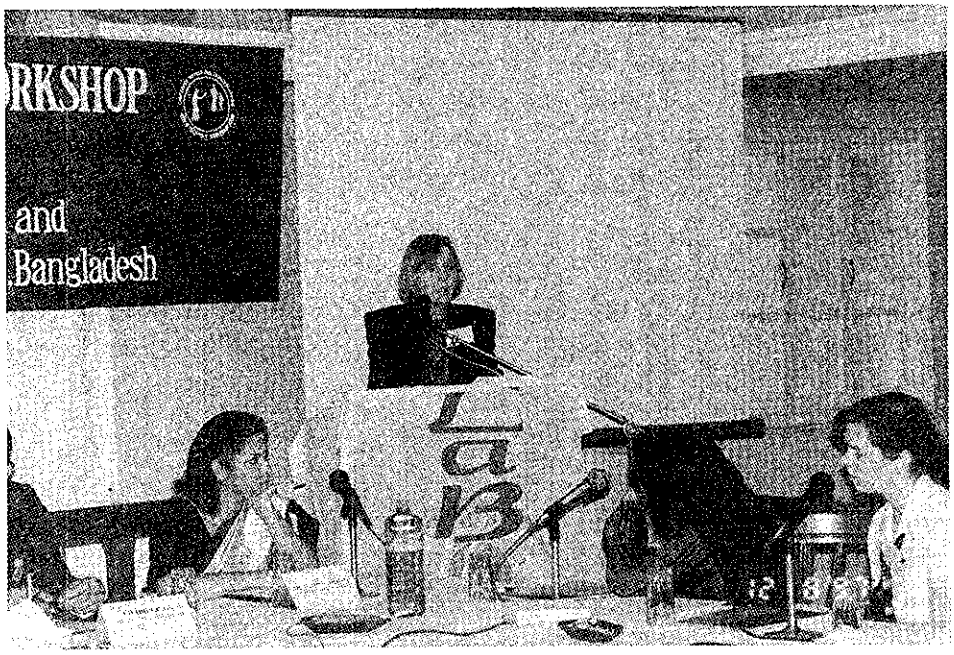
2.2

Mr. Md. Shirajul Islam

DIRECTOR GENERAL
DIRECTORATE OF FAMILY PLANNING

Bismillaher Rahmanur Rahim. Dr. Saroj Pachauri, Regional Director, Population Council, South and East Asia, Anne Aarnes, Deputy Mission Director, USAID, Bangladesh, Dr. Syeda Nahid Mukith Chowdhury, National Program Coordinator, Population Council Bangladesh, Dr. Ubaidur Rob, Population Council, Bangladesh, Ms. Mufaweza Khan, Executive Director, CWFP, Bangladesh and learned participants - Assalamu-Alaikum. I am really happy to be here with you all in this important workshop which is being participated by learned specialist from home and abroad. I am quite confident that this workshop will be of utmost benefit to our national programs. When I received the invitation to attend this workshop, I was thinking, "What is this EC?" Now, from the discussion, I find it quite significant which is already present in our country. When I met some of my workers I asked them, "When somebody fails, how do you tackle this situation, or what do you suggest them?" and they could not give me any proper answer. This is because we did not provide them proper guidelines on this subject. Prior to my speech, I was talking to my project Director who informed me that of course our workers know about such methods but with a vague idea since we have not provided them with enough information. So this is a very important workshop from the point of view of our national program. Bangladesh has gained considerable recognition from the world through it's successful interventions in the field of family planning and we are righteously proud that our programs have achieved a lot during the past decade.

If you go through the Bangladesh Demographic Health Survey you will find a lot of misinformation. This is because of lots of drop-outs and increased MR. The number of MR is quite high in Bangladesh in comparison to other countries. Henceforth, the theme of today's workshop is very important for us. The recent impetus of scientific knowledge and development has provided us with a wider range of preference in modernistic methods, one of which is EC. Although first used in the 1960s, emergency contraceptives are still largely unknown methods compared to the previous conventional methods referring to prevention of pregnancy through use after unprotected intercourse. In Bangladesh, this concept is even more less known to the general people. Only the technical people know about this and we could not include it to our program to provide information to our clients. emergency contraception is undoubtedly a new stone to the pyramid of family planning ascendance and moreover, since the women of Bangladesh, who constitute almost half the country's population - are most vulnerable to unprotected sex, the illiteracy should reciprocate. I am quite confident that today's workshop will be pioneering towards the crusade of thrusting awareness among people on emergency contraception. With both nationally and internationally renowned expertise as its participants, I sincerely hope that the workshop will have considerable implemented impact and perception on the subject. At the same time I request the respective participants to chalk out policies and plans so as to blend the national program in a more effective way, which no doubt you will. I assure you that me and my government have full alliance to such ideas which are definitely supportive to the future progression and expediency in the field of reproductive health. I am sure this workshop will trigger thoughts on issues related to EC. I hope that the experts and the participants will be able to develop some sort of guideline for our national program. I am positive that you will provide us how we should include EC in our national programs and policies. I congratulate the organizers, Population Council and CWFP for arranging such a workshop from which, we will be immensely benefited. I wish every success of the workshop.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2.3

Anne Aarnes

DEPUTY MISSION DIRECTOR
USAID

Good morning. Distinguished chairperson Director General, Family Planning, Dr. Saroj Pachauri Regional Director from the Population Council, Dr. Nahid M. Chowdhury National Program Coordinator for Population Council in Bangladesh, who has organized this workshop, Dr. Ubaidur Rob, distinguished guests and participants, ladies and gentlemen. I am pleased to participate in this inaugural session from the workshop on Emergency Contraception. As Dr. Nahid explained, the workshop is intended to provide all of us with the background history and concepts of EC. The workshop is bringing together key govt. officials and policy-makers as well as private practitioners and program managers from the govt. and NGOs. The workshop will give us an opportunity to enhance our knowledge on the use of EC, of it's problems and of the implications for our programs. We also need to consider very carefully the appropriateness of EC and it's potential role in the Bangladesh family planning program. ECs are important means of family planning that can be of great benefit to women in Bangladesh as well as in other countries around the world by increasing their choices and preventing unwanted pregnancies. USAID is particularly interested in efforts to increase understanding about EC and to explore the potential and implications of expanding the provision of EC in voluntary family planning and reproductive health programs. I would like to highlight a few of the specific issues that we need to consider today and tomorrow these workshop sessions.

One important question is - when does the need for EC arise? In summary the need for EC arises when there is a contraceptive failure. For example when a condom breaks or when an IUD is rejected. It arises when a woman forgets to take pills or misses the time for the next injection and is at risk of getting pregnant. It arises when a woman is subjected to pregnancy against her will. In these circumstances a responsible course of action may be to use EC to prevent an unplanned pregnancy. This can also prevent resorting to abortion to avoid the unwanted pregnancy. An abortion that might be unsafe, expensive, illegal or not easily accessible. A second question is - for whom might EC be an important option? What is the extent of need for EC in Bangladesh? As I just noted, those who are in greater need of EC are contraceptive users who forgot to take their pills or the date of the next injection and those who experience ,method failure and for those women who are forced against their will to risk pregnancy. In Bangladesh adolescents represent a particularly important group and we should consider that they could benefit from EC. About 50% of adolescent girls aged 15-19 in Bangladesh are married and one-quarter of them are mothers. Adolescents are more likely to have high risk pregnancies and unintended pregnancies. The national family planning program gives higher priority to newly-weds and adolescents. So we need to consider whether EC has a role to play in the method mix for this target group.

Finally, a critical question for us to consider is - how would, or how should EC be handled in the family planning program? There are a number of key issues that are involved in this question. Just a few of the more obvious ones are, first - at what level which type of service delivery sites would EC be most appropriately offered? how would the clients be informed about EC? and, what would be the effect of access to EC on other methods previous to the program? Adding another method to the method mix in a family planning program increases woman's choices and increases the choices of couples, but it is not a decision that can be made lightly.

The questions I have just mentioned do not have any easy answers. They are likely to place a significant management burden on a program that has many other problems to address. How the Bangladesh family planning program chooses to address EC will depend on these answers. How costly and complicated these ECs are in terms of requirement for training, information, organization and management of services and products in comparison with its benefits in preventing unwanted pregnancies, reducing abortions and preventing high risk births. Thus, having a positive impact on woman's health. This is a very challenging topic and I an anticipating a lively and fruitful discussion. I am joined here by several of my colleagues of the USAID from the Population and Health Team. Charles and Zareen Khair are here and Margaret Neuse, Team Leader. We are looking forward to the discussions of the next couple of days. We are hoping to participate in the debate and to hearing the conclusions of your deliberations. Thank you very much.

2.4

Welcome Address

Dr. Syeda Nahid Mukith Chowdhury

POPULATION COUNCIL, BANGLADESH

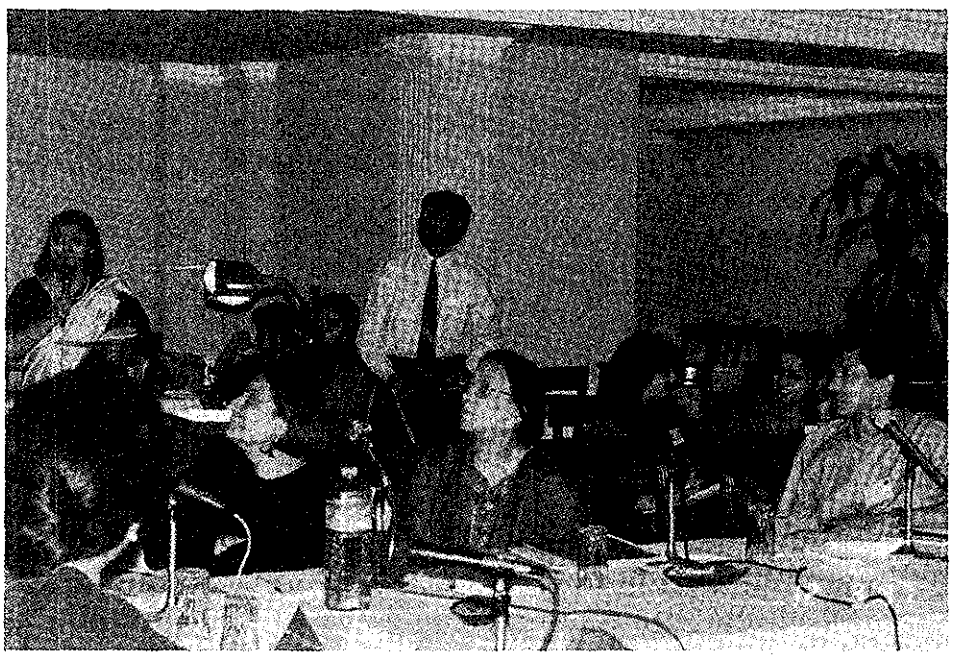
Firstly I welcome all distinguished participants to attend this workshop on the concept and choice of emergency contraception, which have been available in other parts of the world but relatively unknown in our country. Emergency contraception is a method that couples can use after unprotected sex or contraceptive failure. Currently seven organizations are working in the field of reproductive health to form the consortium for emergency contraception - namely The Concept Foundation, International Planned Parenthood Federation, Population Council, Pathfinder International, Program for Appropriate Technology Health and WHO. The consortium is committed in making such pills as a standard part of reproductive health around the world. By making emergency contraception more widely available reproductive health providers can help women to prevent unplanned pregnancies, many of which may result in unsafe abortions. So emergency contraception can also be an essential part of treatment for those who are rape victims. In 1989, when I was visiting UK I saw wide use of emergency contraception and returning to Bangladesh I tried to work with a group of women who were using condoms as a contraceptive measure. These women were counseled and I tried to give them pills that were available at the time and we got a very good response. Recently a brand of emergency contraception has been marketed and looking at newspaper advertisements, I felt the need for some advocacy efforts on this issue because other methods that are available in the National program can also be used as an emergency method. And I was inspired by our Regional Director to undertake activities in this area who herself is a pioneer in this domain.

The process of organizing this workshop was very interesting. I had to communicate with a lot of people from different fields and the reaction was very interesting. The term itself generated a lot of questions - is it a new method? what kind of emergency situation are you talking about? how can a contraceptive be any kind of emergency? - or a simple comment such as - this is not common in Bangladesh or not suitable for our people. The purpose of today's workshop is to learn about experiences with emergency contraception in other countries and to identify the scope of these methods in our national health and FP program as well as to formulate plan for research and action. Lastly, we would also like to develop a network of organizations for formulation of programs on emergency contraception.

Today we are very fortunate to have distinguished speakers from home and abroad. We are very fortunate to have our regional director Dr. Saroj Pachauri from India and my colleagues Dr. Charlotte Ellertson from New York and Dr. N. T. Giang from Vietnam. At the same time we have with us, eminent speakers from Bangladesh. We are honored to have Ms Anne Aarnes, Deputy Mission Director of USAID and Mr. Shirajul Islam, Director General, Directorate of Family Planning. As you will get to know each other you will see that people from various fields are being represented and we felt that representation of all these sectors is very important to promote EC in this country.

Today's and tomorrow's sessions will be devoted in listening to country experiences which shall be followed by group discussion. Each participant is assigned to a group. In the final session there will be a presentation of these group recommendations and we will have a panel discussion.

I hope this turns out to be a very participatory and fruitful workshop. Thank you all.



PRESENTATIONS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3.1

EMERGENCY CONTRACEPTION IN SOUTH AND EAST ASIA

Dr. Saroj Pachauri*

Paper presented at the Emergency Contraception Workshop
Dhaka, Bangladesh
December 9-10, 1997

* **Regional Director, South and East Asia, The Population Council, New Delhi, India**

Global Initiatives

As affirmed at the International Conference on Population and Development in Cairo in 1994, women have the right to control the number and timing of their pregnancies. To realize this right, women need access to contraceptives. While most contraceptives are intended for use before or during intercourse, there are some methods of contraception that a woman can use within a short time after unprotected intercourse. Often called "morning after pills, " these regimens are better named emergency contraceptives to dispel the idea that the woman must wait until the morning after unprotected intercourse to start treatment -- or that she will be too late if she cannot obtain treatment until the afternoon or night after. The term emergency contraception also. stresses that the methods are not for ongoing use (Ellertson, 1996).

At the international level, nine international organizations working in the field of reproductive health have formed a Consortium for Emergency Contraception that is committed to making dedicated products for emergency contraception a standard part of reproductive health care around the world. The Population Council is a member of this Consortium along with WHO/UNDP/UNFPA/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; International Planned Parenthood Federation; Pathfinder International; Family Health International; Population Services International; Pacific Institute for Women's Health; Program for Appropriate Technology in Health; and The Concept Foundation.

Lessons from Global Experience

The experience with emergency contraception in developed and developing countries provides several lessons that may be useful for countries seeking to introduce or expand emergency contraception.

First, it is important that both providers and users be well-informed about emergency contraception, the parameters for its use, and its availability. A significant obstacle to wider use of emergency contraception in both developed and developing countries is lack of information on the part of both providers and users. Because of the short period of time in which emergency contraception can work, women need full knowledge of the method before unprotected intercourse occurs, and ready access to supplies once it does. Few providers receive specific training in emergency contraception and fewer still discuss the method with clients during routine counselling on reproductive health. In the absence of commercially advertised products for emergency contraception most women get their information by word of mouth or from occasional news stories. The result is that while many women have heard something about a "morning after pill", most do not remember enough details about the method to take appropriate action when the need arises. For example, many mistakenly believe that it needs to be taken literally the morning after.

In countries such as the United Kingdom and the Netherlands, where emergency contraception is most widely used, it is well integrated into general family planning services and information and education efforts. Women consult providers not because they had unprotected intercourse, but because they know there is an emergency method available. Emergency contraception has a key place as a backup for method or user failure as well as a last resort in the instance of unexpected intercourse. It should be available from a variety of sources, certainly through general practitioners and family doctors as well through family planning clinics. It appears that emergency contraception is most widely used when it is well integrated into routine care.

Second, it is critically important that emergency contraception not be misconstrued as an "abortion pill. The lack of public information about emergency contraception may be linked to the misconception that emergency contraceptives cause abortion. Actually, emergency contraceptive pills disrupt the menstrual cycle in several ways. They can prevent ovulation, fertilization, or implantation, depending on when in the cycle the pills are taken. Emergency contraceptive pills cannot, however, disrupt an established pregnancy.

A clear distinction must be drawn between emergency contraception and abortion, especially in countries where abortion is legally restricted or where it carries a moral stigma. In fact, emergency contraception should be cast as an important way to reduce the need for abortion. In countries where abortion remains illegal and dangerous, emergency contraception could save thousands of women's lives every year. By reducing the number of unwanted pregnancies, emergency contraception can greatly reduce the need for abortion.

And finally, even in countries that have good data, such as the Netherlands and the United Kingdom, our knowledge of emergency contraception use is incomplete. Therefore, country-specific data on emergency contraception should be collected along with routine family planning statistics.

Post Coital Options

- **The Yuzpe Regimen**: Commonly available oral contraceptive pills that contain ethinyl estradiol and norgestrel can be used for postcoital treatment. This option known as the Yuzpe regimen, requires two doses taken twelve hours apart, totalling 200 mg of ethinyl estradiol and 2.0 mg norgestrel or 1.0 mg Levonorgestrel. Treatment is most effective if initiated within the first 12-24 hours after unprotected intercourse. Treatment is not likely to be effective if delayed longer than 72 hours. Evaluated in numerous studies, this regimen is the most widely used emergency treatment available.

- **Danazol treatment:** This synthetic androgen has been used for emergency treatment with a schedule similar to the Yuzpe regimen. Two doses twelve hours apart, totalling 800mg and three doses, 12 hours apart, totalling 1,200 mg have been evaluated. Research on this treatment is limited. However, the Danazol regimen has a lower incidence of side-effects such as nausea and vomiting so it may be a reasonable option for women who are not able to tolerate oral contraceptives.

- **Progestin-only pill treatment:** Short term use of progestin-only pills has been evaluated as a method for women who have intercourse only intermittently and for emergency use after unprotected intercourse. In the multiple dose regimens studied, pills containing 0.75 mg of Levonorgestrel, have been used, with the first dose initiated no later than eight hours after intercourse. The same dosage is then repeated after 24 hours. If the woman has intercourse on subsequent days, she takes additional doses every 24 hours up to a total of seven doses. Efficacy of this treatment appears to be similar to efficacy with combined oral contraceptive pills, but abnormal bleeding patterns are noticed. However, sometimes appropriate dosage of Progestin-only may not be available. Also, initiating treatment within 8 hours might be problematic. This approach, may be useful in provide care after rape for a woman who should not use oestrogen.

Postcoital IUD insertion: Insertion of a Copper IUD within 5-7 days after ovulation in a cycle when unprotected intercourse has taken place is extremely efficacious in preventing pregnancy.

This option is much less used because:

- the woman who needs emergency treatment may not be an appropriate IUD candidate;
- insertion is not wise if sexually transmitted disease is a possible risk or if preserving fertility is a consideration for the woman;
- it is not a reasonable option after rape or when a woman is just beginning a new relationship; and
- women who have multiple partners or who have a history of pelvic infections or ectopic pregnancy are not ideal IUD candidates.

- **RU 486 (Mifepristone):** Initial studies of RU486, given in a single 600 mg dose within 72 hours after unprotected intercourse, have demonstrated excellent efficacy with a low incidence of side effects such as nausea and vomiting.

Experience in South and East Asia

In this section the experience with emergency contraception in South and East Asia is briefly reviewed to cover India, Sri Lanka, Malaysia, China, Hong Kong, Indonesia, and Vietnam.

India

As a part of its reproductive health and gender programme, the Population Council is undertaking a programme on expanding contraceptive choice in India. The aim is to address clients needs, improve method safety, and expand choice by improving the quality of services. A key strategy that we use in all our work on reproductive health is to bring together, in discussion and dialogue, policy makers, service providers and users, especially women's groups, so that diverse perspectives can be shared and understood by all stake holders and programmes can be designed with the users perspective in mind -- to address the needs of the user.

To understand the perspectives of various stake holders on emergency contraception, we initiated a process of dialogue with different groups. In this process of discussion we discovered that emergency contraception was a well kept secret in India. We found that information on this topic was scanty not only among users but also among service providers; that while there was a need for emergency contraception there was little information available. In fact, the consensus that emerged through our discussion and dialogue with various groups was the expressed need to bring together all concerned constituencies to discuss and share information on this subject, because there were more questions than answers: Is emergency contraception being used in India? To what extent is it used? Is it being used correctly? Who are the users? What are the problems, if any? How can we provide information to those who need it? And so on. We, therefore, decided to convene a workshop.

In December 1996, a Regional Workshop on Emergency Contraception was organized with two objectives:

1. To share experiences related to emergency contraception in developing and developed countries;
2. To identify a possible niche for emergency contraception in the reproductive health landscape in India.

I would like to underscore that our objective was not to promote this technology but rather to learn about it and to assess for ourselves, its place -- in our context -- within the national programme.

This was the first forum convened in India to discuss emergency contraception. Fifty-three participants attended the workshop, representing India and seven other countries (Nepal, Bangladesh, Vietnam, Pakistan, Kenya, the United Kingdom and the United States of America). We made an explicit effort to bring together different stake holders including donors, policy-makers, service providers, women's groups, and the media. We included professionals who organize family planning, abortion, social marketing, and pharmaceutical programmes, as well as grassroots workers and service providers who address the needs, not only for family planning clients, but also of adolescents and of victims of rape and sexual violence. A crosscutting subject that pervaded our discussions was sex and sexuality, and these issues were dealt with up front. Other issues such as legal, ethical, marketing, costs and safety, were also discussed. The question we asked ourselves was how can we most effectively provide information and services to all those who need emergency contraception?

Our two and a half-day workshop ended on a note of excitement and empowerment brought about by a sharing of information and experience. It seemed as though the process towards the introduction of emergency contraception in India had begun and there would now be no looking back. As one of the participants put it -- 'Ale toothpaste is out of the tube and now there is no way in which it can be put back. " Policy-makers and clinicians spoke of the need for building a consensus after launching a public debate on the issue. Researchers expressed a desire to undertake clinical and behavioural research. Media personnel left on a note of promoting processes to provoke a rethinking on current attitudes relating to sexuality -- to exercise the "generation responsibility" of passing down to the next generation, a pro-active and open discussion on sexuality. There was a desire on the part of the media representatives and NG0s to demystify clinical knowledge regarding emergency contraception for its easy access and appropriate use (Population Council, 1996).

As a follow-on to the workshop, the Government of India set up a national committee on emergency contraception. Over the past year, two workshops were organized for service providers. It is recommended that all primary health centre medical officers be trained over a one-year period. Training protocols have been prepared. In addition, three proposals have been submitted to WHO for workshops on emergency contraception.

Recognizing that the major barrier to the use of emergency contraception in India was the lack of information, the Population Council has initiated a media advocacy project that aims at coalition building and information sharing (Nayyar, 1997).

Sri Lanka

In Sri Lanka, a country where abortion is illegal, and contraceptive prevalence is high (67%), several factors combine to produce high rates of abortion. A recent national survey shows an increase in premarital sexual activity in the country. This, coupled with the fact that the government's family planning program does not provide family planning services to those who are unmarried, and that there is a high prevalence of traditional methods, generally known to have low effectiveness, contribute to a high abortion rate. These demographic indicators point to a large potential market for emergency contraception which is now expected to materialize with the availability of a dedicated product.

The Family Planning Association of Sri Lanka (FPASL) launched Postinor-2, a dedicated emergency contraception product in September 1997. The method is available at FPASL clinics around the country and from private providers affiliated with FPASL. A telephone hotline was established to direct interested clients to service providers. A newspaper advertisement announcing the hotline, generated over 150 calls per day during the first two days of operation, a much higher volume than was anticipated. Calls subsequently levelled off at about 100 per day. Besides clients, callers included doctors and pharmacists eager to supply the method. Provision of emergency contraception through pharmacists has been planned. Although the Yuzpe regimen of emergency contraception was already available in Sri Lanka, knowledge of and demand for this method was low. It seems that launching a product specifically packaged and labelled for emergency contraception has generated tremendous interest (Population Council, 1997).

Recently, the Family Planning Association of Sri Lanka conducted a study to assess the need for an emergency contraceptive pill in the country using focus group discussions, in-depth interviews with medical personnel, open forums with midwives, and a questionnaire addressed to general practitioners by mail (Bamunusinghe, et al, 1997).

his study was designed to:

1. understand how the people would view the introduction of an 1 emergency contraception pill;
2. determine the marketing strategy for such a product; and
3. identify the key areas that need to be addressed to market such a product.

The following were the salient study findings:

- The introduction of emergency contraceptive pills in Sri Lanka would have many benefits including the prevention of unwanted pregnancies, the possible reduction of illegal abortions, and improvement in women's health.

- The concerns were that there might be an increase in unwanted sexual activity, especially among adolescent and youth, and that emergency contraception pills may replace regular use of contraceptives. For example, people might stop using condoms which would result in the spread of STD, HIV/AIDS. Other concerns related to long-term health effects of repeated use, failure rates, and the fear that emergency contraception may be viewed as abortion.

- Emergency contraception should first be introduced by doctors and later made available through paramedical staff, midwives, pharmacists, and health volunteers.

- A priority need is to train service providers and to give full information to the general public, specially to parents and youth.

- A price of $ 2-4 or less was suggested for the dedicated product.

Malaysia

Although emergency contraception has purportedly been available in Malaysia since 1966, it was not until 1987 that the first emergency contraception regimen, Postinor, was officially registered in Malaysia. A second regimen, Estinor, was registered three years later. These are reportedly the most commonly used methods. Both brands consist of 0.76 mg tablets of Levonorgestrel. The recommended dose is a single tablet to be taken within one hour after unprotected intercourse. If the woman has engaged in more than one act of intercourse, the manufacturers recommend that a second dose of two Postinor tablets or one Estinor tablet be taken eight hours later. These brands are usually sold in 10-tablet strips -- enough to cover five episodes of unprotected intercourse (Glasier et al, 1996).

In Malaysia, emergency contraception is viewed as an "abortion pill." Since abortion is stringently regulated in Malaysia, this miscategorization of emergency contraception contributes to a shield of silence around the method. Data on emergency contraception are not available from the national family planning programme and there is a scant literature on the method. The government's family planning clinics do not provide the method and the private practitioners who do are reluctant to speak about it. The Family Planning Association of Malaysia responded to a request for information by stating that it was not the policy of the organization to distribute something that acts as an "abortion pill." More recently, the Association developed a protocol for the use of emergency contraception, but still prefers to stress regular use of an effective method (Glasier et al, 1996).

Emergency contraception is marketed legally and is available from pharmacies in Malaysia. It is also available from private practitioners. Although Postinor and Estinor both fall under the Poisons Act, they may be purchased without prescription at pharmacies if the woman provides her name,

address and ID card number to the pharmacist. At pharmacies, an emergency contraception regimen of 10 pills costs approximately $3-6 to the purchaser. At private clinics, which charge a consultation fee as well, the cost for one to three tablets is approximately $4. Based on sales figures for these pills, 60,000 women are estimated to use emergency contraception in the country. Very rough estimates based on sales by pharmacies indicate that at least 20,000 women obtained emergency contraceptives in 1994. The exact number is difficult to determine because some women purchase just the tablets they need to cover one act of unprotected intercourse, whereas others buy extra pills (Glasier et al, 1996).

China

While postcoital contraception is a research area of the State Family Planning Commission Programme, emergency contraception is reportedly not widely used in China. Postcoital contraception was first developed in China in the 1970s, primarily for use by married couples living at distance from one another. As China has demonstrated, traditional emergency contraception regimens as well as variations on them may have applications beyond preventing pregnancy after a single exposure to unprotected intercourse. In China. postcoital methods have not been separated into those advocated for emergency use only and those recommended for ongoing use. Postcoital methods are offered by government family planning services.

China has experimented widely with a variety of "visiting pills" for couples who experience intercourse only infrequently. Such "visiting pills" may also be appropriate for use in other countries with similar marriage patterns or high rates of seasonal migration (Glasier et al, 1996). These are packaged and known as "visiting pills, "vacation pills", and "quick action pills" and often consist of high dosages of norethisterone, megestrol acetate or norgestrel. Other compounds such as quingestanol, norgestrienone and norethisterone acetate-3-oxime are also used. One of the most common compounds is anordrin, synthesized in Shanghai in 1975. It is packaged as a 7.5 mg tablet; one of these is taken at the time of intercourse and one the morning after. The cost is only a few cents. In China, somewhat longer regimens are common. Anordrin, for example, consists of a total of 8 to 10 tablets taken over 12 days, starting on the day after unprotected intercourse.

Although there is extensive literature on the use of visiting pills, there are few reports on the use of these compounds for emergency contraception. Reportedly, IUDs are sometimes inserted in women who have experienced contraceptive failure (broken/slipped condom), but ,as in other countries, it is difficult to distinguish IUD insertions for emergency contraception from others (Glasier, et al, 1996).

The International Peace Maternal Hospital in Shanghai experimented with Levonorgestrel suppositories in the hope that vaginal administration would reduce the nausea and vomiting associated with the elevated hormonal dosage of emergency contraception. However, the method proved less effective than hoped because the tablets were not sufficiently soluble.

China is testing Mifepristone (RU486) as an emergency contraceptive. in a smaller dose than used for abortion, both alone and in conjunction with other hormones. A single dose of Mifepristone (150 mg) is approximately $4. Recent trials have shown that even this single dose of Mifepristone is a promising addition to the methods of emergency contraception. The method is not yet available other than in clinical trials, but family planning advocates hope Mifepristone will be introduced soon for general use as an emergency contraceptive (Glasier et al, 1996).

Indonesia

Pathfinder and WHO/HRP, members of the International Consortium for Emergency Contraception, are working with local partners to prepare the way for emergency contraception in Indonesia. As a first step, a baseline study was conducted in four provinces: Jakarta, West Java, Central Java, and Yogyakarta. This study will be used both to guide the introduction of a dedicated product for emergency contraception, and as a baseline to measure project success. Interviews and focus groups held with 35 policy-makers, 57 health care and family planning providers, and 296 family planning acceptors and non-acceptors revealed that knowledge of this method was extremely low. In fact, not one client knew how emergency contraception worked, or how to use it, and only 4.4% had heard of it at all. Most policy-makers and providers were positive about the method once they received an explanation, but the fear was expressed that if the method were too widely available, it might encourage less adherence to other contraceptive methods. Many respondents, including clients, also suggested that the method should be restricted to married couples (Population Council, 1997).

The research points to the need for a well-crafted introduction strategy, providing technical information to policy-makers and opinion leaders, and engaging in dialogue with religious groups to garner support for the method. It will be important to emphasize that the method is, in fact, contraception and not an abortificient.

Vietnam

A Population Council study of physicians and health care workers in Ho Chi Minh City highlighted the widely divergent medical practice and considerable misinformation about emergency contraception regimens. Most of the respondents had heard of and used Postinor, the Levonorgestrel tablet marketed in a four-pill packet for ongoing postcoital use. Most knew about some version of the Yuzpe regimen using combined oral contraceptives and about postcoital IUD insertion. But a large number also mentioned various ineffective methods, such as postcoital douching and spermicide use. Others had not heard of any emergency method.

There were very divergent prescribing practices. Postinor, for example, was prescribed in regimens that ranged from 1 tablet per week to 4 tablets after intercourse, to one tablet every day, or every other day. The somewhat complex Yuzpe regimen also confused many providers. In addition, most providers overestimated the incidence and severity of side-effects for the regimens and listed needless contraindications to their use, often citing (mistakenly) the full array of contraindications for regular oral contraceptives.

The almost unanimous support among providers for wider use of emergency contraception, and for more information and training, was clearly tied to a desire to reduce the number of abortions in Vietnam. Providers disagreed on the best channels for making the methods available, but all stressed the need for clear packaging and instructions for emergency contraceptive pills (Ngoc, et al, 1996).

Research Needs and Priorities

Because the available information on emergency contraception in developing countries is limited at present, further study is warranted. Clinical trials of existing and new methods of emergency contraception should be undertaken in Asian countries to allow policy-makers and practitioners to gain experience and confidence with these methods. Clinical questions of special significance to the country should receive research priority. Some examples of such research questions are:

- Can any brand of combined oral contraceptive pills be adapted for emergency Use?
- Can the Yuzpe regimen be administered more than five days after unprotected intercourse (Grou and Rodrigues, 1994)?
- What are the exact mechanisms of action involved in each regimen?
- Is a given method compatible 'with the legal or regulatory environment in the country?
- What happens when the method is used in situations that do not offer readily available backup abortion?

Operations and behavioural research on how women can best use emergency contraceptives to suit their needs is crucial, especially in the case of hormonal methods which depend far less on providers. Some research questions that should be addressed are:

- How much do women know about the methods and how might they best learn more?
- How do women in developing countries respond to the option of emergency contraception?
- Are its side effects acceptable to them?
- Is its efficacy high enough to suit their needs?
- Should they be routinely prescribed or dispensed at every family planning clinic?
- Should emergency contraceptive pills be available over the counter and from vending machines?
- Should women be issued an identification card (equivalent to a standing prescription) entitling them to the purchase of a regimen of emergency contraceptives, once they have been screened and counselled about the use of the therapy?
- Would women prefer a specially packaged product to a plain cycle or part of a cycle of oral contraceptives?

Research on providers is also important to address questions such as:

- How do providers feel about the methods?
- How are side-effects best managed?
- Should antiemetics be offered routinely or are they too expensive to use prophylactically?
- How should the methods fit into existing service delivery systems?

The answers to these and other questions will help determine what information should be provided and how, as well as which distribution systems and use patterns would best help women avoid unwanted pregnancy.

Concluding Comments

The ICPD Conference endorsed women's rights to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so (UN, 1994) Emergency contraception provides an additional option for women to realize these rights.

Although emergency contraception has been available for close to three decades, its potential to reduce unintended pregnancy and abortion has begun to be realized but recently. The experience of countries in South and East Asia suggests that emergency contraception should be an established option within the range of family planning services available to all women. Experience shows that emergency contraceptives are simple to use, relatively inexpensive, and in many cases, already accessible to the women who need them. The major constraint or obstacle to use of these methods is lack of information, not only among women who are the users, but also among service providers. Because country -level information is lacking, clinical and behavioural research is needed to design effective strategies to enhance availability of information and services for women. By reducing the number of unwanted pregnancies, emergency contraception can greatly reduce the need for abortion.

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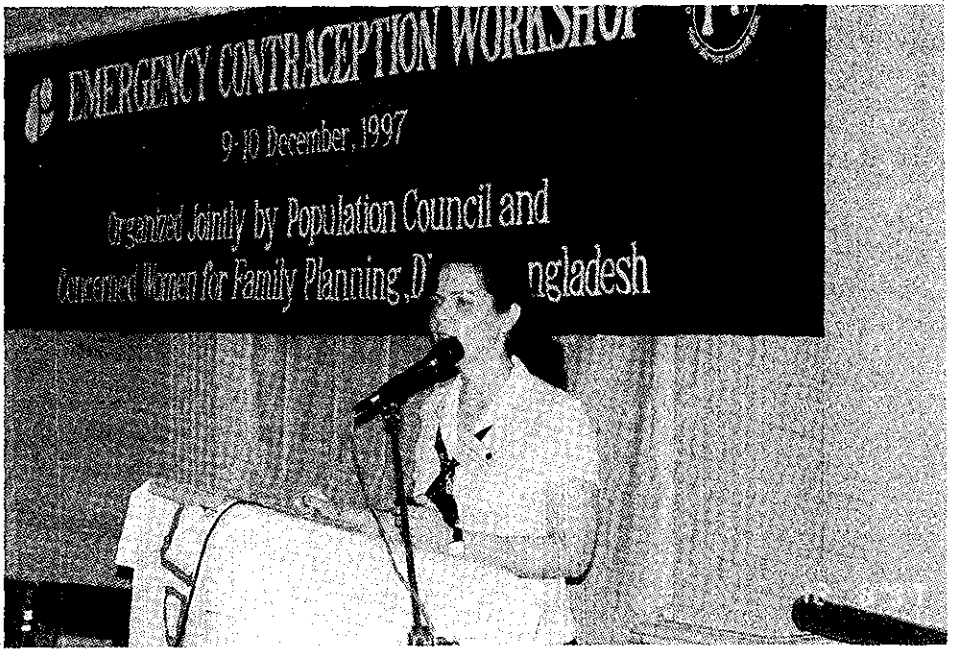
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EMERGENCY CONTRACEPTION: A COST-EFFECTIVE APPROACH TO PREVENT UNINTENDED PREGNANCY

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Paper presented at the Emergency Contraception Workshop
Dhaka, Bangladesh
December 9-10, 1997

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Emergency Contraception: A Cost-Effective Approach to Prevent Unintended Pregnancy

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Half of all pregnancies in the United States are unintended: there were 3.2 million in 1994 alone, the last year for which data are available.[1] Emergency contraception, which prevents pregnancy after unprotected sexual intercourse, has the potential to reduce significantly the incidence of unintended pregnancy and the consequent need for abortion.[2] Emergency contraception is especially important for outreach to the 3.1 million women at risk of pregnancy but not using a regular method[3] by providing a bridge to use of an ongoing contraceptive method. Although emergency contraceptives do not protect against sexually transmitted infection, they do offer reassurance to the 7.9 million women who rely on condoms for protection against pregnancy[3] in case of condom slippage or breakage. Emergency contraceptives available in the United States include emergency contraceptive pills (ECPs), minipills, and the copper-T intrauterine device (IUD).[4,5,6]

Emergency Contraceptive Pills (ECPS)

ECPs are ordinary birth control pills containing the hormones oestrogen and Progestin. Although this therapy is commonly known as the morning-after pill, the term is misleading; ECPs may be initiated sooner-immediately after unprotected intercourse-or later-at least 72 hours after. The only hormones that have been studied in clinical trials of ECPs are the oestrogen ethinyl estradiol and the Progestin Levonorgestrel or norgestrel (which contains two isomers, only one of which - Levonorgestrel-is bioactive). These are found in seven brands of combined oral contraceptives available in the United States (Table 1).[7]

Effectiveness. Use of ECPs reduces the risk of pregnancy by about 75%.[8,9] This statement does not mean that 25% of women using ECPs will become pregnant. Rather, if 100 women have unprotected intercourse once during the second or third week of their cycle, about 8 would become pregnant; following treatment with ECPS, only 2 would become pregnant: a 75% reduction. The current treatment schedule is one dose within 72 hours after unprotected intercourse, and a dose 12 hours after the first dose. Research suggests that ECPs are not more effective when started earlier or less effective when started later in the 72-hour window[10] and it is biologically implausible that efficacy would abruptly plummet to zero after 72 hours.[11] This finding has two clinical implications. First, clinical protocols that deny treatment beyond 72 hours seem excessively restrictive, particularly if the alternative of emergency insertion of a copper-T IUD is not immediately available or appropriate. Second, a recommendation to take the first dose as soon as possible might well be counterproductive in circumstances when taking the second dose 12 hours later would be difficult; for example, a woman who took her first dose at 3 p.m. immediately following discovery of a burst condom might understandably fail to take the second dose at 3 a.m. The goal should be to make the therapy as user-friendly as possible.[12]

Side Effects. About 50% of women who take ECPs experience nausea and 20% vomit.[8] If vomiting occurs within 2 hours after taking a dose, some clinicians recommend repeating that dose. The results of one study suggest that ECPs containing Levonorgestrel have an incidence of side effects substantially lower than do ECPs containing norges;[13] see note *c* to Table 1 for information on progestins in ECPS. Non-prescription anti-nausea medicines such as meclizine may reduce the risk of nausea when taken 0.5 to 1.0 hour before ECPs (see Appendix for dosage). Anti-nausea medicines are not routinely offered in the United States. Instead, many providers of ECPs recommend that women take them with food to reduce the risk of nausea, although no data other than anecdotes exist to validate this advice.

Safety. Almost all women can safely use ECPs. The-only absolute contraindication to use of ECPS is confirmed pregnancy, simply because ECPs will not work if a woman is pregnant, Treatment may not be appropriate for those who. have an active migraine with marked neurological symptoms or crescendo migraine.[14] Given the very short duration of exposure and low total hormone content,

ECP treatment can safely be considered for women who would ordinarily be cautioned against use of combined oral contraceptives for ongoing contraception. Although no changes in clotting factors have been detected following ECP treatment Progestin-only pills or insertion of a copper IUD may be preferable to use of ECPs for a who has a history of stroke or blood clots in the lungs or legs and wants emergency contraceptive treatment. All three of these conditions (pregnancy, migraine, or history of thromboembolism) are identified through medical history screening, so most women requesting ECPs be evaluated via telephone, without need for an office visit, pelvic exam or laboratory tests.

There have been no conclusive studies of births to women who were already pregnant when they took ECPs or following failure of ECPS. However, there are two observations that provide reassurance for any concern about birth defects.[5] First, in the event of treatment failure, ECPs are taken long before organogenesis starts so that they should not have a teratogenic effect. Second, studies that have examined births to women who inadvertently continued to take oral contraceptives without knowing they were pregnant have found no increased risk of birth defects.[16,17] The FDA removed warnings about adverse effects of oral contraceptives on the fetus from the package insert several years ago.[18]

Mechanism of Action. Several clinical studies have shown that ECPs can inhibit or delay ovulation.[19,20,21] This is an important mechanism of action and may explain ECP effectiveness when used during the first half of the menstrual cycle, before ovulation has occurred. Some studies have shown histologic or biochemical alterations in the endometrium after treatment with the regimen, leading to the conclusion that ECPs may act by impairing endometrial receptivity to implantation of a fertilized egg.[20,22,23,24] However, other studies have found no such effects on the endometrium.[19,25] Additional possible mechanisms include interference with corpus luteum function; thickening of the cervical mucus resulting in trapping of sperm; alterations in the tubal transport of sperm, egg or embryo; and direct inhibition of fertilization.[5,26] No clinical data exist regarding the last three of these possibilities. ECPs do not interrupt an established pregnancy, defined by the National Institutes of Health[27] and the American College of Obstetricians and Gynecologists[28] as beginning with implantation.

Minipills

Minipills are birth control pills that contain only Progestin (and not oestrogen). They are called minipills because they contain no oestrogen and even less Progestin than is found in ordinary oral contraceptives containing both oestrogen and Progestin. only the Progestin Levonorgestrel, found in the minipill Ovrette,, has been studied for use as an emergency contraceptive. The treatment schedule is one dose within 72 hours after unprotected intercourse, and a second dose 12 hours after the first dose (Table 1). Twenty tablets are needed for each dose. The only published randomized trial comparing the two regimens found that minipills are as effective as ECPs, but nausea and vomiting are far less common;[29] a recently completed but as yet unpublished trial conducted by the World Health Organization confirmed these findings and extended the treatment window from 48 hours[29] to 72 hours following unprotected intercourse. For most women who cannot safely tolerate oestrogen, minipills are an excellent alternative to ECPs.

The Copper-T IUD

The copper-T IUD can be inserted up to the time of implantation-about five days after ovulation-to prevent pregnancy. Thus, if a woman had unprotected intercourse three days before ovulation occurred in that cycle, the IUD could be inserted up to eight days after intercourse to prevent pregnancy, Because of the difficulty in determining the expected cycle day of ovulation, however,

many protocols allow insertion up to only five days after unprotected intercourse. Emergency insertion of a copper-T IUD is significantly more effective than use of ECPs or minipills, reducing the risk of pregnancy following unprotected intercourse by more than 99%. [30] Such a degree of effectiveness implies that emergency insertion of a copper IUD must be able to prevent pregnancy after fertilization. A copper-T IUD can also be left in place to provide effective ongoing contraception for up to ten years. But IUDs are not ideal for all women. Women at risk of sexually transmitted infections (STIs) may not be good candidates for IUDS; insertion of the IUD in these women can lead to pelvic infection, which can cause infertility if untreated. Women not at risk of STIs have little risk of pelvic infection following IUD insertion.[31]

Barriers to Use of Emergency Contraception

The lack of a product specifically packaged, labelled, and marketed as an emergency contraceptive is a major obstacle to more widespread use of emergency contraception. Although the Food and Drug Administration (FDA) has not specifically approved combined or Progestin-only birth control pills or IUDs for emergency contraception, providing these products for this indication is legal. Once a medication or device has been tested and approved for one use, it is a legal and medically accepted practice to prescribe it for other appropriate uses.[32] For example, many women take birth control pills not to prevent pregnancy, but to regulate their rnenstrual periods, to decrease rnenstrual tramping, or to prevent the recurrence of ovarian cysts. The FDA's reproductive health drugs advisory committee reviewed research concerning ECP treatment in 1996 and concluded that existing data were sufficient to document the safety and efficacy of this regimen, and the agency then took the unusual action of publishing in the *Federal Register* a notice declaring ECPs to be safe and effective:

> The Food and Drug Administration (PDA) is announcing that the Commissioner of Food and Drugs (the Commissioner) has concluded that certain combined oral contraceptives containing ethinyl estradiol and norgestrel or Levonorgestrel are safe and effective for use as postcoital emergency contraception.... The Commissioner bases this conclusion on FDA's review of the published literature concerning this use, FDA's knowledge of the safety of combined oral contraceptives as currently labelled, and on the unanimous conclusion that these regimens are safe and effective made by the agency's Advisory Committee for Reproductive Health Drugs at its June 18, 1996 meeting.[18:8610,8611]

Even though some doctors have been prescribing emergency contraceptives since the 1970s, no company has applied to the FDA to market birth control pills or IUDs for emergency use. While considerable international research attests to the safety and efficacy of emergency contraceptives manufacturers cannot market or advertise these products for postcoital use until they seek and gain formal FDA approval for this specific purpose. Without commercial promotion, it is not surprising that physicians prescribe emergency contraceptives infrequently and rarely provide information about emergency contraception to women during routine visits. As a consequence very few women know that emergency contraception is available, effective, and safe.[33] A recent college campus survey found that while nearly all students were aware of ECPs and knew available they were available at the college health center--because of an effective publicity campaign--few knew that ECPs were ordinary combined oral contraceptives, and many could not distinguish ECPs from Mifepristone, a medication taken to induce abortion after pregnancy has been confirmed.[34]

One objection to making ECPs more widely available is the concern that women who know they can use ECPs may become less diligent with their ongoing contraceptive method. Several studies are currently being conducted to address this issue empirically. In the absence of direct evidence to the contrary, them are several considerations that lessen this concern, If used as an ongoing method, ECP therapy would be far less effective than any other contraceptive method; therefore,

continued use would not be a rational choice. Moreover, one in two women experiences nausea and one in five women vomits after taking ECPS. If anti-nausea medicines are used, the incidence of nausea and vomiting might be halved, but not eliminated. This risk is likely to dissuade such users from having unprotected intercourse often. Reported evidence with providing ECPS, although limited, suggests that women who are the most diligent about ongoing contraceptive use are those most likely to seek emergency treatment.[35] And finally, even if ECP availability did adversely affect regular contraceptive use, women are entitled to know about all contraceptive options.

To help educate women and men about emergency contraception, the Reproductive Health Technologies Project in Washington and the Office of Population Research at Princeton University sponsor the toll-free Emergency Contraception Hotline (1-888-NOT-2-LATE) and the Emergency Contraception Website (http://lopr.princeton,edu/EC/). Since it was launched on February 14, 1996, the Hotline has received more than 75,000 calls. More detailed information is available on the Emergency Contraception Website, which has received more than 170,000 hits since it was launched in October 1994. Both the Hotline and Website are completely confidential, available 24 hours a day in English and Spanish, and offer names and numbers of providers of emergency contraception located near the caller's area. The Reproductive Health Technologies Project has received funding from several foundations to work with the advertising and public relations firm Elgin DDB to develop public service announcements for print, radio, television, and outdoor venues. During the last year, a public education campaign was launched in five test cities (Chicago, Los Angeles, Miami, San Diego and Seattle) in partnership with a coalition of local organizations and clinicians in each area.

Cost-Effectiveness

Use of ECPs or emergency minipills reduces expenditure on medical care by preventing unintended pregnancies, which are very costly. Insertion of a copper-T IUD is not cost saving in the United States when used solely as an emergency contraceptive. Unlike the other two alternatives, however, insertion of a copper-T IUD can provide continuous contraceptive protection for up to 10 years thereafter, producing savings if used as an ongoing method of contraception for as little as four months.[36] ECPs are cost-effective regardless of whether they are provided when the emergency arises or provided beforehand as a routine preventive measure.[7,37]

Not only would making emergency contraception more widely available save medical care dollars, but also additional social cost savings would result. These include not only the monetary costs of unwanted pregnancies and births but also the considerable psychological costs of unintended pregnancy. Moreover, the average medical care cost of unintended births is likely to be greater than the average cost of all births.[38]

Emergency contraceptives would be even more cost-effective in the United States if they were not inefficiently packaged. In other countries, specifically packaged and labelled products are available. In the United Kingdom, for instance, a packet of four PC4 tablets---enough for one course of therapy-is sold by Schering to the National Health Service for $2.20.[39] Similarly, in many countries, a tablet containing the 0.75 mg Levonorgestrel found in 20 Ovrette minipills is available. In Malaysia, a brand called Postinor (marketed as a routine postcoital contraceptive, not as an emergency contraceptive) costs about $3-6 for a ten-pill strip.[39] Postinor-2 (a two-pill strip of Postinor tablets specifically packaged and labelled as an emergency contraceptive) will be marketed in many countries by the Hungarian pharmaceutical company Gedeon Richter. Because of the lower incidence of side effects, the Levonorgestrel-only regimen may replace emergency contraceptive pills containing both oestrogen and Progestin. Although such products would

undoubtedly cost more in the United States than in many other countries, specifically labelled emergency contraceptives would be more convenient for women and providers.

Conclusion

Unintended pregnancy is a major public health problem that affects not only the individuals directly involved but also society.[38] Insurers in both the public and private sectors generally cover the medical costs of unintended Pregnancy Outcomes, with coverage for abortion showing the most variation. Some private insurers provide broad coverage for all contraceptive methods but most do not.[40] Public payers generally provide broader contraceptive coverage than private payers, although payment levels often are low, perhaps low enough to limit access.[41] Extending explicit coverage to emergency contraception would result in cost savings by reducing the incidence of unintended pregnancy. Making emergency contraceptives more, widely available in the United States is one of the most important steps that can be taken to reduce the incidence of unintended pregnancy and the consequent need for abortion.[2,7,42]

Several service delivery innovations would also enhance the potential for emergency contraception to reduce significantly the number of unintended pregnancies. Perhaps the greatest impact would result from changing provider practices so that women seen by primary and reproductive health care clinicians would be routinely informed about emergency contraception before the need arises. The recent clinical practice pattern issued by the American College of Obstetrician and Gynecologists[43] should help clinicians achieve this goal. Additional resources include a monograph of legal issues for health care providers of ECPs produced by the Center for Reproductive Law and Policy[44] and a provider packet developed by the Program for Appropriate Technology in Health[45] and endorsed by many medical organizations (including the American Medical Association, the American College of Obstetricians and Gynaecologists and Planned Parenthood Federation of America). Information could be provided to women (and men!) during counselling or by posters, brochures, audio or video cassettes, or wallet cards. Access would be enhanced if clinicians advertised. emergency contraception services and if emergency contraceptives were prescribed by telephone without the need for an office visit. A more proactive step would be to prescribe or dispense emergency contraceptive pills to women in advance so the therapy would be immediately accessible if the need arises. Availability would also be enhanced if companies sought FDA approval for and then actively promoted emergency contraceptives. The recent FDA notice[18] in the *Federal Register* declaring ECPs to be safe and effective has made gaining approval far easier in addition to giving explicit official sanction for ECP use, and the health care company Gynetics has announced that it will bring a specifically labelled and dedicated ECP product to market in 1998.

Table 1: Eight brands of oral contraceptives that can be used for emergency contraception in the United States

Brand	Manufacturer	Pills per Dose[b]	Ethinyl Estradiol per Dose (mg)	Levonorges per Dose
Ovral	Wyeth-Ayerst	2 white pills	100	0.50
Alesse	Wyeth-Ayerst	5 pink pills	100	0.50
Nordette	Wyeth-Ayerst	4 light-orange pills	120	0.60
Levlen	Berlex	4 light-orange pills	120	0.60
Lo/Ovral	Wyeth-Ayerst	4 white pills	120	0.60
Triphasil	Wyeth-Ayerst	4 yellow pills	120	0.50
Tri-Levlen	Berlex	4 yellow pills	120	0.50
Ovrette	Wyeth-Ayerst	20 yellow pills	0	0.75

Source: Trussell *et at.* (1 997)[7]

Notes:

a) Ovral, Alesse, Nordette, Levlen, Lo/Ovral, Triphasil, and Tri-Levlen have been declared safe and effective by the Food and Drug Administration.18 Outside the United States, emergency contraceptive products are specifically packaged, labelled, and marketed. These have more convenient dosing schedules than all but one of the regimens listed above. The German pharmaceutical company Schering markets a four-pill strip with each pill containing 50 ug ethinyl estradiol and 0.25 mg Levonorgestrel under four brand names: PC4 in New Zealand and the United Kingdom, NeoPrimovlar in Finland, E-Gen-C in South Africa, and Tetragynon in Denmark, Germany, Norway, Switzerland and Sweden (personal communication from Loutz Schafran, Director of International Family Planning at Schering AG, to Sharon Camp, November 12, 1997). The package insert for PC4 incorrectly describes a formulation that is no longer used (with each pill- identical to Ovral--containing 50 ug ethinyl estradiol and 0.50 mg norgestrel). The Hungarian pharmaceutical company Gedeon Richter plans to market the Levonorgestrel-only product Postinor-2, a two-pill strip with each pill containing 0.75 mg Levonorgestrel,

b) The treatment schedule is one dose within 72 hours after unprotected intercourse, and another dose 12 hours later.

c) The Progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is, bioactive; the amount of norgestrel in each tablet is twice the amount of Levonorgestrel.

Appendix

Reducing the Risk of nausea

- OTC: 2 meclizine hydrochloride (Dramamine II, Bonine) 25-mg tablets 1 hour before the first ECP dose
- OTC: 1-2 diphenhydramine hydrochloride (Benadryl) 25-mg tablets 1 hour before each ECP dose; repeat as needed every 4-6 hours
- OTC: 1-2 dimenhydrinate (Dramamine) 50-mg tablets or 4-8 teaspoons Dramamine liquid 30 minutes to 1 hour before each ECP dose; repeat as needed every 4-6 hours
- OTC, 1 cyclizine hydrochloride (Marezine) 50-mg tablet 30 minutes before each ECP dose; repeat as needed every 4-6 hours
- Rx: 2 meclizine hydrochloride (Antivert) 25-mg tablets 1 hour before the first ECP dose.
- Rx: 1 trimethobenzamide hydrochloride (Tigan) 250-mg tablet or 200-mg suppository 1 hour before each ECP dose; repeat as needed every 6-8 hours
- Rx: 1 promethazine hydrochloride, (Phenergan) 25-mg tablet or suppository 30 minutes to 1 hour before each ECP dose; repeat as needed every 8-12 hours

Kaiser Family Foundation Poll[33]

- OB/GYNs
  - 99% are familiar with ECPs (77% very familiar, 22% somewhat familiar)
  - 70% have no objections/concerns about ECPs
  - Among the 67% who do not perform abortions, 64% have no concerns about prescribing ECPs
  - 70% prescribed ECPs last year (77% of whom did so five or fewer times)
  - Among those with objections to abortion, 48% prescribed ECPs last year
- Women
  - only 1% have ever used ECPs
  - only 26% have accurate knowledge

Action Steps for Providers

- Ensure that all office staff (especially those answering the telephone) know that you provide emergency contraception
- Routinely discuss emergency contraception with clients
- Do not require a pelvic exam before prescribing ECPs or minipills
- Prescribe ECPs by telephone to clients
- Provide ECPs in advance to clients
- Discuss anti-nausea medicines with clients
- Consider extending 72-hour window when prescribing ECPs
- Join the directory of providers listed on the Emergency Contraception Website and the Emergency Contraception Hotline
- Advertise the availability of emergency contraception in your office/clinic

Emergency Contraception Resources

- Emergency Contraception Website. http://opr.princeton.edu/EC/
- Emergency Contraception Hotline: 1-888-NOT-2-LATE
- *Emergency Contraceptive Pills.. Common Legal Questions about Prescribing, Dispensing, Repackaging, and Advertising,* New York NY: The Center for Reproductive Law and Policy, 1997 To order, call 212-514-5534.
- *Emergency Contraception: Resources for Providers.* Seattle WA: Program for Appropriate Technology in Health, 1997. To order, call 1-800-669-0156.
- Emergency Oral Contraception. *ACOG Practice Patterns.* Number 3. Washington DC: The American College of Obstetricians and Gynecologists, December 1996. To order, call 508-750-8400.

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3.3

SCOPE OF EMERGENCY CONTRACEPTION IN BANGLADESH

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Paper presented at the Emergency Contraception Workshop
Dhaka, Bangladesh
December 9-10, 1997

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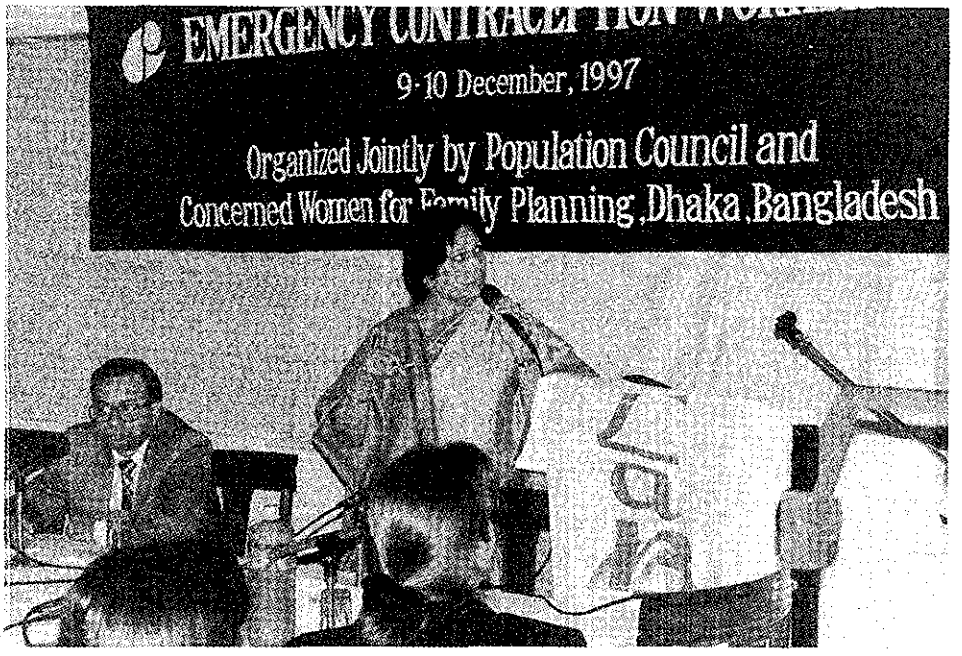

EMERGENCY CONTRACEPTION
9-10 December, 1997
Organized Jointly by Population Council and
Concerned Women for Family Planning, Dhaka, Bangladesh

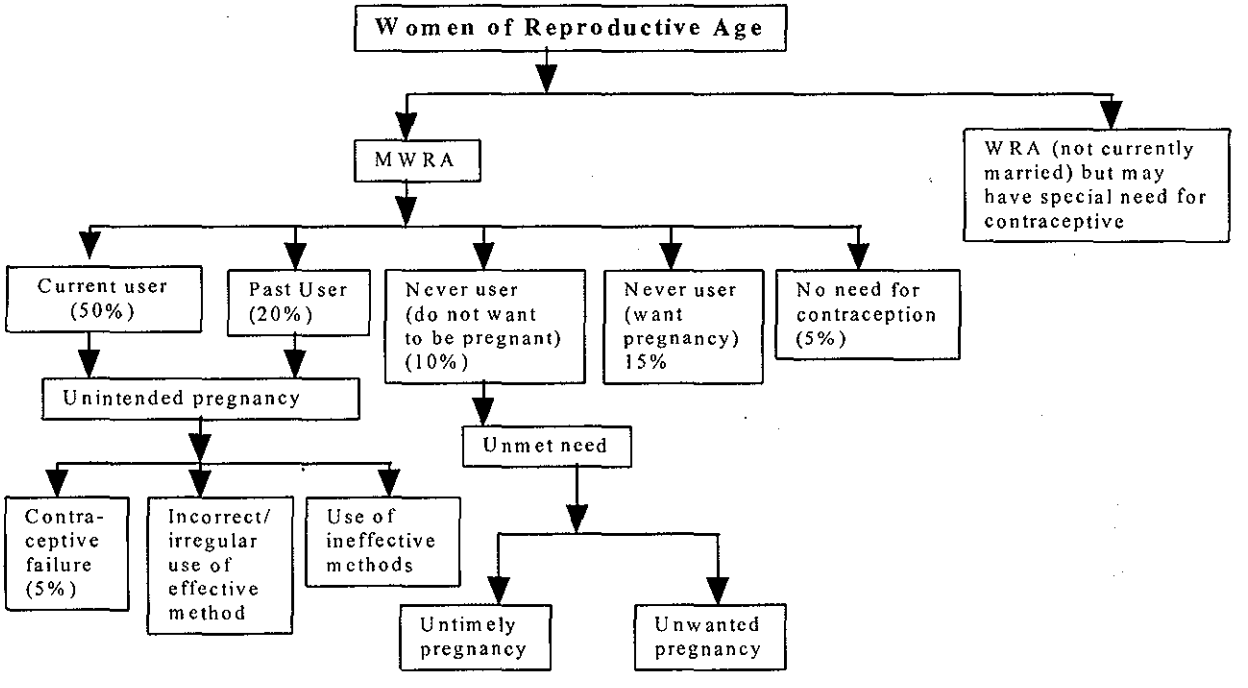
Scope of Emergency Contraception in Bangladesh

It is well known to the workers of family planning clinics, practising physicians, paramedics and friendly neighbors of a couple that in some months there exits doubts about full protection from unwanted conception. This has happened because either condom broke, pills forgotten, safe period calculation was wrong, personal carefulness was not adequate, unpredicted mating because of infrequency, supply was exhausted etc. and the woman or the couple are scared.

I had a phone call from a friend "Your advice worked very well last time, what should I do this time - we think we were not very careful" etc. Long ago when 1 was a student 1 have seen my gynaecologist mother prescribing menstrogen injections, describing how to take those and telling the couple why could they not have come earlier.

I do not have formal publications or reports to share experiences on use and prescription of emergency contraception but I definitely have many events and cases which I can cite. Feeling unprotected, 'doubling conception might occur' are part of life for those who are sexually active. During my family planning clinical practice days I have given advice, prescriptions, pills etc. to many women. Some came very late, some early and something was possible to do. Some postcoital interventions showed successful results which made the couple happy.

For any community we can not deny the need for emergency contraception, more so, the knowledge and awareness about emergency intervention of the unprotected event. To describe and explore the scope of emergency contraception in Bangladesh. I would like to reflect the contraceptive use related scenario and relevant conceptual framework to estimate the scope. The conceptual framework below shows the level of contraceptive use, non-uses and prevalence of unintended pregnancy among MWRA reflecting scope for emergency contraception.



According to BDHS '96-97 contraceptive use is nearly 50 percent. MWRA who are past users of contraceptive are about 20 percent, never used contraceptive and do not want to be pregnant is nearly 10 percent, 15 percent MWRA want pregnancy and never used a contraceptive and a small proportion who may not need any contraceptive. There may be a special group of not currently married women who are at risk of becoming pregnant and need knowledge and methods to protect themselves from unwanted pregnancy.

Contraceptive prevalence rate as found in Bangladesh demographic health survey (BDHS) in 1996-97 reflect that 41.5 percent of married women of reproductive age (MWRA) use modern contraceptive, 7.7 percent of them use traditional methods and overall 49.2 percent of couples use some form of contraception. While one fifth of modern method users accept permanent method and four fifth use temporary methods, half of the modern method users use oral pills, 15 percent use injectables and nearly 10 percent are condom users. Nearly 16 percent of all contraceptives users use traditional methods such as periodic abstinence, withdrawal and other traditional methods. The table 1 reflects the percentage of currently married women age 10-49 who are currently using specific family planning methods, Bangladesh 1993-97.

Table 1: Current use of family planning methods as found in BDHS 93-94 and 96-97

Method	1993-94 BDHS	1996-97 BDHS
Any method	**44.6**	**49.2**
Any modern method	**36.2**	**41.5**
Pill	17.4	20.8
IUD	2.2	1.8
Injectbales	4.5	6.2
Condom	3.0	3.9
Female sterilization	8.1	7.6
Male sterilization	1.1	1.1
Any traditional method	**8.4**	**7.7**
Periodic abstinence	4.8	5.0
Withdrawal	2.5	1.9
Other traditional methods	1.1	0.8
Number of women	8980	8450

Table 2: Current use of family planning by selected background characteristics, BDHS 1996-97

Background characteristics	Any method	Any modern method	**Not Currently using**
Age			
10-14	15.6	9.1	**84.4**
15-19	32.9	27.8	**67.1**
20-24	43.1	37.6	**56.9**
25-29	52.5	46.0	**47.5**
30-34	63.1	54.0	**36.9**
35-39	63.9	51.8	**36.1**
40-44	54.7	42.7	**45.3**
45-49	35.1	27.6	**64.9**
Residence			
Urban	62.1	52.5	**37.9**
Rural	47.6	40.1	**52.4**
Number of livingchildren			
0	16.4	11.3	**83.6**
1	42.3	35.6	**57.7**
2	58.1	50.9	**41.9**
3	59.5	51.0	**40.5**
4+	54.6	45.4	**45.4**
Total 8450			

Review of age specific proportion of married women of reproductive age who are currently non users show that non use is higher among age groups younger than 25-29 years and over 40-44 years and lowest proportion (36 percent) of non use is found among age groups 30-39 years.

Need for family planning services and unintended pregnancies:
Fecund women who are currently married and who say either they do not want any more children or that they want to wait two or more years before having another child, but are not using contraception, are considered to have an unmet need for family planning.' Women who are using family planning methods are said to have a met need for family planning. Women with unmet and met need constitute the total demand for family planning. Table 3 presents data on unmet need, met need, and total demand for family planning, according to whether the need is for spacing or limiting births.

Percentage of currently married women age 10-49 with unmet need for family planning, and met need for family planning, and the total demand for family planning services, by selected background characteristics, Bangladesh 1993-94 is shown below in table 3.

Table 3: Need for family planning services

Background Characteristics	Unmet need for family planning: For spacing	For limiting	Total	Met need for family planning (currently using)	Total demand for family planning	**Percentage of demand satisfied**
Age						
10-14	30.3	0.0	30.3	22.1	53.2	**43.0**
15-19	22.3	0.8	23.1	24.7	48.8	**52.7**
20-24	15.8	5.9	21.7	37.6	61.5	**64.7**
25-29	10.2	9.3	19.5	50.6	71.8	**72.8**
30-34	5.5	15.5	20.9	57.2	79.6	**73.7**
35-39	2.8	16.3	19.1	58.5	79.2	**75.9**
40-44	0.6	10.6	11.2	51.9	63.3	**82.3**
45-49	0.5	6.4	7.0	29.3	36.2	**80.8**
Residence						
Urban	7.1	8.6	15.7	54.4	72.0	**78.2**
Rural	10.8	9.0	19.8	43.3	64.5	**69.3**
Total 8980	**10.4**	**9.0**	**19.4**	**44.6**	**65.3**	**70.3**

According to BDHS 93-94, one-fifth of married women in Bangladesh have an unmet need for family planning services (table 3) 10 percent for spacing purposes and 9 percent for limiting births. Combined with the 45 percent of married women who are currently using a contraceptive method, the total demand for family planning comprises almost two-thirds of married women in Bangladesh (Table 3).

1 Unmet need for spacing *includes pregnant women whose pregnancy was mistimed, amenorrheic women whose last birth was mistimed, and women who are neither pregnant nor amenorrheic and who are not using any method of family planning and say they want to wait two or more years for their next birth. Also included in unmet need for spacing are women who are unsure whether they want another child or who want another child but are unsure when to have the birth. Unmet need for limiting refers to pregnant women whose pregnancy was unwanted, amenorrheic women whose last child was unwanted and women who are neither pregnant nor amenorrheic and who are not using any method of family planning and who want no more children. Excluded from the unmet need category are pregnant amenorrheic women who became pregnant while using a method (these women are in need of better contraception). Also excluded are menopausal or infecund women.*

Currently, 71 percent of the demand for family planning is being met. The estimate of 19 percent unmet need for the BDHS (Table 3), combined with the current level of contraceptive use or met need, or 45 percent suggests that, theoretically, close to two-thirds of couples would use family planning if services were available. The increase of CPR found in BDHS'96-97 unmet need has come down to nearly 10 percent. An often-neglected aspect of unmet need is women who previously used contraception but have subsequently stopped. In Bangladesh, this has consistently been almost one-third of ever-users. While there may be numerous reasons for discontinuing, there is clear evidence that dissatisfaction with methods, primarily due to side effects, is by far the major reason.

Some studies have shown that although point prevalence of contraceptive use is reasonably high in Bangladesh but scope for compliance is low as because most users use temporary methods as shown in table 2 and compliance rate is low among these users leading to unintended pregnancies.
In Bangladesh where 50 percent of modern method users are pill users, a large proportion use irregularly and have higher risk of pregnancy or method failure.

A recent study on compliance, continuation and failure rates and reported side-effects of low-dose and standard dose oral pill in rural Bangladesh conducted by BIRPERHT during 1995 shows that wrong information are still quite prevalent and are being practised by large proportion of oral pill acceptors. The table 4 shows that during 3 month follow-up interview, 58 and 65 percent pill users mentioned taking pill irregularly and at 6 month follow-up 34 percent and 46 percent reported irregular pill taking.

Table 4: Distribution of the acceptors of both types of pill by their practice of taking oral pill

	3 month follow-up		6 month follow-up	
Practice of taking oral pill	Std. dose	Low dose	Std. dose	Low dose
Regularity in taking pill	**n=565**	**n=580**	**n=320**	**n=371**
Regular	41.6	35.5	66.3	54.4
Irregular	58.4	64.5	33.8	45.6

The most commonly reported irregularities were missing pill one day once, one day more than once separately, several days separately and more than three days consecutively. The table-5 shows that missing pill for more than three days and several days separately have been most commonly reported irregularities in pill taking.

Life table continuation rate reflect that only half of the standard dose acceptor continue and 64 percent of low dose acceptors continue use upto 6 months. This date reflect that 50-60 percent of the pill acceptor continue upto 6 months (Table 5). When discontinuation rates for 'all reasons combined' are compared between standard and low dose OC acceptors during 1st to 6th months of use, all duration specific discontinuation rates were significantly higher among acceptors of standard dose OC than among the acceptors of low dose OC (Table 5).

Table 5: Comparison of two types of pill by their cumulative discontinuation rates for "all reasons combined" during 1-6 months of use

Month	Standard dose	Low dose
1st	20.7	13.4
2nd	28.4	20.8
3rd	35.9	26.7
4th	40.0	30.6
5 th	45.4	35.0
6 th	48.8	36.5

Table 6: Distribution of the acceptors by their irregularity status in taking oral pill by type of oral pill accepted at 3 month and 6 month interview

Irregularity status	3 month follow-up Std. dose n=330	3 month follow-up Low dose n=374	6 month follow-up Std. dose n= 108	6 month follow-up Low dose n= 169
Type of irregularity				
One day once	17.0	27.3	11.1	29.6
One day more than once separately	13.9	20.9	11.1	10.7
Two days once/or several occasion	10.6	5.9	14.9	14.2
More than two days	5.8	3.8	12.0	11.1
More than three days	27.0	21.1	27.8	23.1
Several days separately	25.8	21.1	23.1	12.4

When the acceptors asked about the type of measures they took for their irregularities in taking pills, for one day missing pills only about one third took appropriate measures and two third took inappropriate or incorrect measures. In case of two days missing pills only small proportion took correct measures and majority took incorrect measures although the number of acceptors was small. When three or more pills were missed, majority took wrong and incorrect measures (Table 7).

Table 7: Distribution of the acceptors by their measures taken for irregularity in taking oral pill by type of oral pill accepted at 3 month and 6th month interview

Measures taken for irregularity	3 month follow-up Std. dose	3 month follow-up Low dose	6 month follow-up Std. dose	6 month follow-up Low dose
For one day once missing	**n=102**	**n=180**	**n=24**	**n=68**
Took appropriate measure	66.6	69.4	33.3	66.2
Followed incorrect ways	**33.3**	**30.6**	**66.7**	**33.9**
For two days missing	**n=35**	**n=22**	**n=16**	**n=24**
Took appropriate measure	2.9	-	-	-
Do not know/followed incorrect ways	**97.2**	**100.0**	**100.0**	**100.0**
For three or more days missing	**n=108**	**n=93**	**n=43**	**n=56**
Took appropriate measure	0.9	-	-	-
Do not know/followed incorrect ways	**99.1**	**100.0**	**100.0**	**100.0**

The scope for emergency contraception could be presented by showing the number of women who undergo indigenous abortion and menstrual regulation in the country will reflect the extent of unwanted pregnancy and efforts to discontinue the suspected pregnancy.
A survey was conducted to study "Events Associated with Reported Contraceptive Failure, Perceived Barriers to Access MR Services and Spousal Support" in a nationally representative rural sample of married women of reproductive age (MWRA) and 3020 MWRA were interviewed.

The unintentional pregnancy status:
Of 3020 MWRA respondents show that 91 percent of respondents were with at least one pregnancy with outcome and among women 14 percent reported having had one unintentional pregnancy, 7.1 percent reported two unintentional pregnancy, over 3 percent reported three unintentional pregnancies

and 2.3 percent had 4-9 unintentional pregnancies during their lives. Mean unintentional pregnancy per woman was found to be about 0.5 i.e. for two MWRA (with at least one pregnancy outcome) there occur one unintentional pregnancy (Table 8).

Table 8: Distribution of respondents reporting unintentional conceptions during their lives

Status	n=2747	percent
Never been pregnant unintentionally	2013	73.3
Had one pregnancy unintentionally	385	14.0
Had two pregnancy unintentionally	196	7.1
Had three pregnancy unintentionally	91	3.3
Had 4-9 pregnancy unintentionally	62	2.3
Mean unintentional pregnancyper woman (sd)		0.49 (1.006)

When lifetime number of pregnancies of the respondents were cross tabulated by their number of unintended pregnancies following relationship were observed (Table 9).

Table 9: Distribution of women's total number of pregnancies by number of unintended pregnancies during their lives

Number of conception	Number of unintended pregnancies n=2747*	0	1	2	3	4-5
1	n=390	97.2	2.8	-	-	-
2	n=502	95.0	5.0	-	-	-
3	n=447	81.4	17.0	1.6	-	-
4	n=388	64.9	25.8	8.8	0.5	-
>5	n= 1020	53.0	17.0	15.2	8.7	6.0

*62 women were currently pregnant with first time pregnancy are not in this table

When all of 3020 MWRA respondents were asked whether they had experienced pregnancy while using a contraceptive method, nearly 5 percent reported to became pregnant while they were using contraceptive (Table 10).

Table 10: Distribution of women experiencing conception during contraceptive method use

Experienced conception during contraceptive use	n=3020
Experienced	4.7
Did not experience	95.3

The women who experienced conception during contraception, were asked about the methods they were using when they became pregnant. Nearly 51 percent were using oral pills, 13.4 percent were using safe period, 9.2 percent condom, 8.5 percent IUD and 7 percent were using injectables (Table 11).

Table 11: Distribution of women who experienced conception while using the methods

Type of contraceptives use	n= 142
Oral pill	50.7
Injection	7.0
IUD/CuT	8.5
Condom	9.2
Foam/Jelly/Diaphragm	1.4
Azal	6.3
Safe period	13.4
Ligation	2.1
Vasectomy	0.7
Banaji/Kabiraji	4.2
Homeopathy	1.4

Women were asked about what they wanted to do when they realized that they became pregnant. Nearly 47 percent of women indicated that they wanted to continue pregnancy, 37 percent said they wanted to do menstrual regulation (MR) and 16 percent said she wanted to have induced abortion (Table 12).

Table 12: Distribution of respondents by their desire to deal with their unintended pregnancies

Desired to deal with this conception	n=142
Wanted to continue the pregnancy	46.5
Wanted to do MR	37.3
Wanted to abort	16.2

While reporting the outcome of the unintended pregnancies occurring while practising contraceptive, nearly one third (31 percent) women reported that she had undergone menstrual regulation, 4.9 percent had induced abortion done and 58.5 percent reported having live births (Table 13).

Table 13: Distribution of respondents reporting unintended pregnancies by outcome of those pregnancies

Status of pregnancy outcome	number	percent
MR was done	44	31.1
Had full term live birth	83	58.5
Had spontaneous abortion	3	2.1
Induced abortion was done	7	4.9
Pregnancy continuing	5	3.5
Total	142	100.0

Those women who had unintended pregnancy nearly 47 percent realized about their pregnancy status at around 2 months of gestation, 20 percent at 3 months, 12 percent at 4 or more months and only 15.5 percent realized relatively earlier, i.e.- before one month of gestation (Table 14).

Table 14: Distribution of respondents who had unintended pregnancies by their duration of gestations at the time they realized that they were pregnant

Duration of gestation (in month)	n=142	percent
< 1 month	22	15.5
2 months	66	46.5
3 months	37	20.0
> 4 months	17	12.0

Those mothers who had unintended pregnancy and had realized that they were 4-7 months pregnant while using contraceptives, majority (88 percent) had livebirth and 12 percent had induced abortion. Those who realized about pregnancy at 3 months gestation, majority (67.6 percent) had live births and 13.5 percent had MR. Those who realized about their unintended pregnancy at 2 months gestation, nearly 49 percent had MR and those who realized at one month of gestation 32 percent had MR, 4.5 percent had induced abortion (Table 15).

Table 15: Distribution respondents reporting unintended pregnancy during contraceptive use and duration of gestation specific outcome of the pregnancy

Duration of gestation (in month)	n=142	Did MR	livebirth	Natural abortion	Induced abortion	Pregnancy continue
1	22	31.8	59.1	-	4.5	4.5
2	66	48.5	45.5	1.5	1.5	3.0
3	37	13.5	67.6	5.4	8.1	5.4
4-7	17	-	88.2	-	11.8	-

As one of the outcome of unwanted pregnancy estimated number of MR and abortion procedures occurring annually in the country will serve as an indicator of scope of emergency contraception. Following table reflect estimated annual number of MR and induced abortion performed in a specific time frame.

Table 16: Selected studies on estimation of annual number of abortion/MR procedures, morbidity and mortalities

Study source	Annual national estimated no. of procedure	Morbidity	Mortality
1. Rochat'78 et al	7,80,000	-	8000
2. Singh et al'97	468,299	90,766 (Hospitalized)	Not reported
3. BIRPERHT National maternal mortality survey	213,379-461,916	46,495	2254

1996-97 estimates show that annually nearly 4.7 lac MR/abortion procedure are done in the country which is a direct reflect of unwanted pregnancy. Thus ration between abortion procedure to absolute number of annual livebirth is nearly 1:6 or 16 percent.

Estimation of unintended pregnancy experience

Table 17: Experience of unintended pregnancy among a rural cross-section of 3020 MWRA is shown in the following table:

Status of Contraceptive use	Number of women experience who experienced unintended pregnancy	Number of MWRA	No. of women reporting unintended pregnancy per 1 000 MWRA	Estimated no. of MWRA who unintended pregnancy in life time
Never user	182	1119	163	10,75,800
Past user	138	542	255	10,20,000
Current user	414	1359	305	33,55,000
Total	734	3020		54,50,800

Thus, an estimated total number of 54,50,800 MWRA experienced unintended pregnancy out of 22 million MWRA. Therefore, 25 percent of MWRA estimated to become pregnant unintentionally in their life time.

Unintentional conception rate per thousand MWRA was estimated among the 2747 women, one unintended conception rate was found to be 74.7 per thousand ever user, two unintended conception rate was 8.9 per thousand ever user and three or more unintended pregnancy rate was 1.6 per 1000 ever user in rural area of Bangladesh. Thus the table show that 1000 contraceptive users experience 97 unintended pregnancy (Table 18).

Table 18: Distribution of women by number of time they had experienced pregnancy during method use

No. of times women became pregnant unintentionally	No. of women who became pregnant	Rate per 1000 women who ever used contraceptives
One time	142	74.0
Two time	17	8.9
Three time	3	1.6

Estimate of the scope for emergency contraception:

- Crude birth rate of the country = 23.6/1000 population
- Current total population of the country = 124 million
- At CBR 23.6/1000 total birth of the country in a year $= \frac{23.6}{1000} \times 124\text{million} = 3$ million
- MWRA of the country = 22 million (18% of total population)
- Current user MWRA = 11 million (CPR is 50%)
- Unintentional pregnancy rate per 1000 ever user = 97.0/1000
- Total unintentional pregnancies among 11 million MWRA of currently contracepting

  $= \frac{97}{1000} \times 11$ million = 1.1 million
- Proportion of unintentional pregnancy out of total annual births $= \frac{970000}{3000000} \times 100 = 32.3$ percent
- This estimate leads us to state that nearly 32.3 percent of annual births are unwanted

Suggested future activities on emergency contraception in Bangladesh:

1 A needs assessment from couple survey on the need of emergency contraception in their life.
2. Centre based research on acceptability of some postcoital regimes.
3. Recognizing the need and in response to the necessity of raising awareness among the population an emergency contraception corner' could be established in medical facilities and other social welfare centres.
4. Broadening of the knowledge on emergency contraception could be done by preparing a simple, easily understood newsletter in the country's language and distributing to medical and paramedic community. Men should be targeted separately for additional information on contraceptives and emergency contraception.
5. National Technical Committee should discuss the emergency contraception and set policies in favour of reflecting it in the national program. It may also be discussed in the form of postcoital contraception as one of the additional choices in the contraceptive mix to address the large unmet demand of the couple.
6. The method should be made available through govt. facilities as well as private sector, NGO and over the counter in pharmacy.

In conclusion, 1 strongly feel that much need to be done in this area and in addition to involving medical and paramedical community, other women's groups, large-factory/employers organizations of both men and women, social service centres and income generating programs should be involved for increasing awareness on this intervention and thus protecting women from risks of unwanted pregnancies.

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3.4

EMERGENCY CONTRACEPTION - SERVICE PROVIDERS CONCERN AND CONSIDERATION

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Paper presented at the Workshop on Emergency Contraception
Dhaka, Bangladesh
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Emergency contraception is a simple, safe and effective way of preventing unwanted pregnancies. Emergency contraception, if easily available and widely used, can prevent a significant number of unwanted pregnancies.

The following is a list of methods that can be used as emergency contraception

Table 1 Methods Available for Emergency Contraception

Method	Time of initiation	Regime	Side Effects/Problems
Combined Oral Pills	*72 hours latest* *Rpt after 12 hrs.*	*100* ugm *E. E* *+0.5* mg. laevo-*norgestral*	*Usual side-effects. of pills?Foetal effects if used in pregnancy*
Progesterone Pills	*8 hours* *Rpt after 12 hrs*	*0.75*mg.*Laevo-norgestral*	*Nausea less*
Only Oestrogen Tabs *vomiting*	*48 hours*	*5 mg. E. E.*	*Sever nausia and*
	Rpt daily 5 days	-	*?DES-relatedproblems*
Danazole	*72 hours* *Rpt after 12hrs*	*400-600 mg*	*Virilising symptoms*
CU-TIUCD	*5 days*		*services of health worker needed.Not suitable for STD-prone women*
RU 486	*72 hours* *Rpt after 12 hrs*	*600 mg*	*Not easily available*

E.E: Ehinyl oestradiol

Emergency contraception ought to become an established option in the range of family planning methods available to women. Furthermore, emergency contraception may well fill up an important gap among groups whose needs have gone unmet by traditional family planning programmes (Anna Glasier et al 1995).

Existing recommended regimes are generally inexpensive, and often consist of the proper use of widely available medications using a different regime.

The question that naturally would be asked whether emergency contraception is effective or not. The answer is an emphatic 'yes'. The question then arises if they are effective why women do not use them? In many countries both the lack of knowledge and availability may contribute. Even in developed countries many women do not know about the existence of emergency contraception. For example one study showed that 30% of British women did not know about emergency contraception. And among those who knew, 10% did not know where to get it from[2] (Duncan et al 1990).

Then what are the hurdles against their use ?

The hurdles that have been identified include

1. The most daunting, despite experience spanning decades is continued ignorance of the method amongst the health care personnel as well as potential users[3]. Both women and the providers are often uninformed. Because of the short time frame within which the methods have to be used, both of them should be fully conversant about the method before they actually need it. Many women world-wide do not know that emergency contraception exists or are available. Many family planning providers also lack adequate knowledge on emergency contraceptive methods and practices (FHI Survey)

2. Products which are specifically earmarked for use as emergency contraception is often not available as such
3. Some providers may be reluctant to provide such services because of a variety of perceived ideas (Consensus Statement)

Time is a critical factor in the effective use of emergency contraception, which will prevent pregnancy. IUDs must be inserted within 5 days. Hormonal methods are most effective if used within first 24 hours of unprotected intercourse and most hormone regimens must be initiated within a period of 72 hours at the latest to be effective. Progesterone only pills must be given within 8 hours of intercourse, while oestrogen pills, if used should be started within 48 hours[4] .

Many women are discouraged from using emergency contraception because they do not get access to emergency contraception soon enough.

Except in countries where emergency contraception drugs are available over the counter, women must rely on provider willingness for their supply.

In 1993 and 1994, Family Health International surveyed 1586 health care professionals in 15 countries on emergency contraception practices. Among the 209 respondents, it was found that emergency contraception was not being practised widely. Even health care professionals who offered emergency contraception prescribed vastly different doses or regimes.

Emergency contraception if easily available and widely used can prevent a significant number of unwanted pregnancies. In many developing countries the consequences of unintended pregnancies are more detrimental to the health and well-being of women than in developed countries. Emergency contraception can be potentially life saving under such circumstances.

In many developing countries induced abortions are illegal and consequently clandestine abortions are often performed. Reducing the need for abortion in such circumstances would reduce abortion-related mortality and morbidity and other negative health effects of such procedures.

Somewhere between 10-22 million abortions are performed annually illegally all over the world excluding Europe and North America. Undoubtedly many of these women would have been eligible for emergency contraception and would have accepted and preferred such a procedure if it were available to them. Abortion mortality has been estimated to be between 67000 to 204,000 per year in developing countries[5].

Unsafe abortions also leave behind hundreds and thousands of women with long-term health problems including infertility. Treating complications of unsafe abortions can place major strain on

the often-meagre health budgets of many developing countries. In such situations emergency contraception can be of great importance.

In Bangladesh by conservative estimate 8,00,000 abortions are performed annually. They contribute to one quarter of all maternal deaths in this coutry[6]. There is no doubt that many of these abortion-related deaths could have been avoided if women had easy access to emergency contraception. If the use of emergency contraception is to have a significant impact on the abortion rates, then it must be made easily available.

The arguments that are put forward against their widespread use are

- the concern for safety of the women and lack of opportunity for follow-up.
- there may be genuine contraindication to their use such as established pregnancy or history of thrombo- embolism.
- the possibility that a minority of women would be using emergency contraception repeatedly, though in such circumstances it is likely that most of them would find the methods inconvenient for repeated use and would ultimately opt for long term regular contraceptive use.
- free availability of emergency contraception would lead to loss opportunities for proper counselling of the users but this is not a valid argument since large number of contraceptives such as condoms and oral pills are now easily available even through both medical and non-medical outlets.
- drug control regulations are lax in many countries and many drugs intended for use under strict medical supervision ultimately falls in the hands of untrained health providers or quacks with a risk of misuse.
- women may use emergency contraception as a method for procuring abortion taking it too late, or multiple doses,(with serious side-effects) or can take them too frequently in place of regular contraception.

Provider Bias

- Introduction invariably depends on provider bias. Some of the providers may be reluctant to use new technology readily.
- It may also threaten the value system of providers who have a paternalistic or moralistic attitude towards women and may consider the free availability of these methods as an invitation for loose morality.
- Emergency contraception dispensed prophylactically require the provider to secede control over his authority and may be a reason for reluctance to provide such methods.

On the other hand many providers who would readily embrace and enthusiastically use such technologies, which will improve their area of service provision. and may consider emergency contraception as a valuable and desirable option for women.

Side Effects:/Problems

- Nausea and vomiting is particularly common after taking oestrogen pills and even sometimes after using combination type of oral contraceptive pills. This may require repetition of the dose and obtaining additional supply may lead to delay in administration, because cost and time involved in getting additional supply. Can act as a disincentive.

- Countries where there is still a unmet demand for contraception, investment in emergency contraception may be viewed as misuse of scarce resources by policy makers, though this is not necessarily true. Even in regularly contracepting women, there are occasions when emergency contraception may be required and can avert a potential pregnancy (e.g. broken

condoms, forgotten pills, unintended intercourse, exhaustion of regular supply at an inconvenient time or place etc.)

Health professionals in many developing countries are in a position to expand the knowledge and availability of emergency contraception, even without any special attempt from the government. Nevertheless, organised efforts my professional associations and women's health advocated can help to legitimise and standardise emergency contraception, and can ensure that these drugs are included in the national essential drug list.

To popularise emergency contraception

- Awareness of both providers and users should be increased
- Both provider and user should be fully informed about the availability, cost, advantages and disadvantages of different method that are available
- Emergency contraception must be differentiated from abortions
- Inclusion of emergency contraception as a back-up for method failure in family planning programme

Risks

- Method failure may lead to resentment or grievances unless properly counselled
- Without proper information users can start late but remains confident about success and may turn up late for a risky second trimester abortion
- Risk is greatly increased if pregnancy continues after insertion of a Cu T
- Unchecked use of such contraception, which may lead to the possibility of indulgence in easy sex and promiscuity may have serious ethical objection from some section of the community.

Recommendations

1. Formulation of standard protocols for use as emergency contraception
2. Propaganda and education on emergency contraception
3. Availability through informed and motivated health workers and not necessarily doctors only

Suggested future activities for introducing emergency contraception on a large scale

1. KAP Survey on emergency contraception amongst health providers
2. Need assessment
3. Research on acceptability and side effects of different post-coital contraceptives
4. Creation of special facilities for the delivery of such service
5. Simple, easily understandable, directions for use in the languages patient understands
6. Inclusion in the national family planning programme as an additional contraceptive method

7. Availability through private sector, NG0s, dispensing pharmacies, social marketing outlets with special warning that they should not be used for the purpose of termination of pregnancy

8. Women's group, youth organisations, social service centres, factories employing particularly young women etc. should be initially targeted for introducing emergency contraception

9. As there are very few products specifically marketed as emergency contraceptives, manufacturers should be advised to manufacture and market appropriate drugs.

10. Pharmaceutical companies should be encouraged to publicise accurate and complete information regarding these products to health care providers

11. Service providers who are reluctant to use emergency contraception should be properly counselled to remove any perceived ideas from their minds.


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3.5

EMERGENCY CONTRACEPTION AND MALE RESPONSIBILITY

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Paper presented at the Workshop on Emergency Contraception
Dhaka, Bangladesh
December 9-10, 1997

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Background

"The first thing we want to know when a baby is born is: "Is it a girl? Is it a boy?" This defining characteristic - male or female - determines our roles in families and society from that moment of birth until we die. The presence of a Y chromosome shapes our experiences, our opportunities, our treatment by others.

We need to recognize the immense variability of individuals and partnerships and embrace a notion which is much broader. We must be able to imagine a different world in order to create it."

-Cynthia Steele

"Men can play a great role in making people realize that they can have more control over their sexual behavior. To achieve this, women and men have to be able to communicate open and honestly about sex and in a way that puts no one in jeopardy. We have to be partners in the truest sense of the world."

- Richard Ongom

Some Myths

There are some commonly held misconceptions and myths about providing services to men. The four common myths are:

Myth #1: Men aren't interested in family planning or reproductive health.

Myth #2: Men will only talk to male service providers.

Myth #3: Serving men is too expensive.

Myth #4: Providing services for men takes away resources and services for women.

Young men can play a great role in making people realize that they can have more control over their sexual behavior. To achieve this, women and men have to be able to communicate open and honestly about sex and in a way that puts no one in jeopardy. We have to be partners in the truest sense of the work.

Role of men in the use of emergency contraception has been reviewed in this paper in the context of male as a policy maker, as a provider and lastly as user of services

Male as policy Makers, Program Designers, Managers and Supervisors

⇨ In Bangladesh almost all of them are males.

⇨ Male policy makers. Program managers and supervisors should commit and make others commit to improve the situation of males taking up more responsibilities in family health which includes use of emergency contraception.

⇨ The commitment shall have to be transformed to bring a change in the work culture

Male as the provider of FP-MCH and Reproductive health Services

⇨ ***Directorate of FP:***

- 752 Male and 129 Female doctors
- 1995 Male and 305 Female MAs
- 4500 Male FPIs.

⇨ ***Directorate of Health***

- 6000 Physicians, 3/5th are Male.
- 1309 HIs, all Male
- 14381 Male and 4198 Female HAs.

⇨ ***NG0s:***

- 60% staff and workers are all Males.

⇨ ***Social Marketing Company:***

- Sellers at the Pharmacies, Grocery Shops and Kios are all Males.

All male service providers should avail the missed opportunities of interacting with male customers and convey the message of proactive participation and taking up increased family life responsibilities.

Male As The User Of Contraceptive Methods And Reproductive Health Services.

⇨ Men have positive attitudes about Family Planning.
⇨ 90% of Men have information about modern methods and sources of supply.
⇨ 97% of Men agree with their wives about Family Planning.
⇨ Husbands are generally less likely than their wives to know about IUD and Injectable.
⇨ Disapproval of Husbands has a much stronger influence on the discontinuation of methods.
⇨ Use of modern methods among males is very low (hardly 5%).
⇨ Men do not have enough information to make good decisions regarding child birth.
⇨ Husbands do not stop their wives to avail antenatal care services.
⇨ Men are involved in decision making for termination of unwanted pregnancies.
⇨ Men are involved in high risk sexual behavior.
⇨ Men are not reached.

Men need to be reached, enough and complete information need be given to them which will help in better decision making and an increased sharing of responsibility.

Forward Thinking Actions

⇨ Orientation of male service providers, supervisors, policy makers and workers to turn them into role models of being supportive in nature.

⇨ All males in the services sector should be trained in the art and technique of counselling men.


CONTRACEPTION WORKSHOP
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3.6

EXPERIENCE OF PATHFINDER INTERNATIONAL IN EMERGENCY CONTRACEPTION

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Paper presented at the Workshop on Emergency Contraception
Dhaka, Bangladesh
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A. Introduction:

It is important to note that emergency contraceptive pills (ECP) are a backup method for unprotected intercourse or contraceptive method failure and, as such, represent one of a range of contraceptive methods provided by national programs. Therefore, the introductory process should ensure that ECP are included in a program's overall family planning training materials/curricula; information, education, and communication (IEC) materials; and logistics and distribution systems.

Despite the availability of highly effective methods of contraception, many pregnancies are unplanned and unwanted as all current methods of contraception sometimes fail. Emergency contraception is an important backup when routine contraception fails to work properly, as when a condom breaks or a diaphragm or IUD becomes dislodged. These pregnancies carry a higher risk of morbidity and mortality, often due to unsafe abortion. Many of these unplanned pregnancies can be avoided using emergency contraception. Moreover Offering emergency contraception is an important way by which family planning and reproductive health programs can improve the quality of their services and better meet the needs of their clients, Emergency contraception is needed because no contraceptive method is 100 percent reliable and few people use their methods perfectly each time they have sex.

For couples who did not use any contraceptive but wish they had, emergency contraception provides a critical second chance to prevent an unwanted pregnancy. Young people in particular may not be prepared for their first sexual experience. Worldwide, one of the most critical uses for emergency contraception has been in cases of sexual assault. Rape crisis centers routinely provide emergency contraception, even in countries where the method is not generally in use.

To address the above issues, seven organizations working in the field of reproductive health have joined forces to form the Consortium for Emergency Contraception. The Consortium is committed to making emergency contraceptive pills--a widely studied form of emergency contraception--a standard part of reproductive health care around the world. The member organizations are:

- Pathfinder International (Boston);
- The Concept Foundation (Bangkok);
- International Planned Parenthood Federation (London);
- Pacific Institute for Women's Health (Los Angeles);
- Population Council (New York);
- Program for Appropriate Technology in Health (Seattle);
- WHO Special Program of Research, Development and Research Training in Human Reproduction (Geneva).

ECP-project in Indonesia is one of four ECP Demonstration project organized by the Consortium of Emergency Contraception. Project Title: "Demonstration project to introduce Postinor II in Indonesia". Demonstration will last for 2-3 years. ECP project in Indonesia has been running since September 1996.

B. Emergency Contraceptive Pill Implementation in Indonesia:

The consortium for Emergency Contraception has decided to conduct an introductory trial of Emergency Contraceptive Pill [ECP] in four countries namely Kenya, Sri Lanka, Indonesia and Mexico.

In Indonesia, the ECP consortium core team consists of Pathfinder International, WHO/HRP, and PATH. The WHO/HRP and Kusuma Buana Foundation are working on the baseline survey and project evaluation. PATH is responsible for developing IEC materials and communication strategies for the project. In addition, the consortium has been working very closely with the IAOG and BKKBN.

The Pathfinder is coordinating the consortium's activities and also in collaboration with IPPA is responsible for the service delivery and training component of the project. Activities during the first year consist at least 9 steps:

1. Established organizations involved (multi organization)
2. Select project personnel (multi discipline)
3. Determine resource requirement
4. Built support for ECP introduction at appropriate level: (Government officials, Policy, community, religious leader, and Professional organization etc..
5. Assess user needs and existing services capabilities - Baseline Survey
6. Arrange for product registration
7. Introduce the product via pilot clinics. Reporting and recording should be done to monitor potential users.
8. Monitor and evaluate implementation
9. Disseminate project evaluation result.

The first introductory meeting on ECP was hosted by Pathfinder at BKKBN in Jakarta on August 1996. The second meeting was in November 1996 where the consortium member from Concept, WHO/HRP and Pathfinder International, met with Indonesian Regulatory Authorities and representatives of the national FP Coordinating Board to discuss on the registration requirements of the Postinor 2.

Further in December 1996, advocacy and participatory planning meeting was organized involving NGOs , representatives of religious groups, women's organizations etc.

As per as ECP Project implementation in Indonesia is moving relatively well.

(a) ECP-monthly coordination meetings among the members of consortium running well. Most of monthly the meeting are to discuss individual program activities: For example PATH talking about the activities to prepare IEC material, translate IEC material and also talking about strategy in addressing target audience, as well as to talk about the content of IEC material.

Pathfinder shared with other members of the team (PATH. WHO, YKB, Pop. Council , BKKBN) in preparing 12 clinics of IPPA translating training material into Indonesia.

(b) Presentation on the result of ECP baseline data survey was conducted on Monday June 09, 1997. More then 30 person attended the meeting. Dr. Peter Hall of WHO/Geneva, Ms. Regan of Concept Foundation, Mr. Nemes of Gedeon Richter, officials from Central BKKBN, Moslem organization , donor agencies, women organization were among the participants. Presentation done by Dr. Firman Lubis, Dr. Joedo Prihartono and Miss. Djoewarino of YKB. A lot of information was collected from the survey. Those information is very important in developing IEC material by PATH and also to provide a good input to conduct training for providers at twelve clinics of IPPA.

ECP baseline data was also presented to ECP Consortium at Nairobi meeting in July 1997.

(c) PATH is responsible for reviewing IEC material to use at the clinic and community level. Four color leaflets have been finalized and distributed via 13 Pilot Clinics.

(d) A Meeting between IPPA - IPPA Regional officer and Pathfinder as ECP coordinator was conducted on April 11, 1997 to discuss role of IPPA in ECP project in Indonesia.

(e) Representative of Gedeon Richter visited Jakarta on June 09, 1997. Gedeon Richter will provide 2,400 ECP Pills to start pilot project in Indonesia. ECP Pill for pilot clinics was available in Jakarta end of July 1997.

(f) On July 31, 1997, Pathfinder Jakarta received 2,400 Postinor II from WHO Office Geneva for training providers. Training providers of 13 pilot clinics service activities started end of September 1997.

(g) Registration of Dedicated project. Contract Agreement between Gideon Richter and PT. Tunggal signed October 1997. Registration process is being done by PT Tunggal to MOH Directorate General of Drugs and Food Administration.

B.1. Baseline Survey on ECP in Indonesia:

Given the magnitude of the problems associated with adolescent pregnancy, drop-out rate and method failure, ECP have the potential to meet the unmet need and reduce abortion rate in Indonesia. A baseline study was undertaken in four provinces, namely Jakarta, West Java, Central Java, and Yogyakarta.

Objective of the study:

The survey was conducted from February to May 1997. The overall objective of the study was to gather information which could be utilized as a "base line information" for the introduction of ECP into the existing FP program in the country.

The survey also was designed to assess the level of knowledge and understanding of policy makers and leaders at the national and provincial levels on ECP along with identifying their opinions and attitude towards ECP. The survey also gathered information on clients perspective on ECP and identified the training needs and necessary managerial adaptations to provide quality ECP services.

The respondents of the study:

The respondents of the baseline study consisted of:

1. Structured interviews with 296 family planning acceptors and on acceptors at 4 IPPA's clinic, 7 Public Health Centers (4 rural and 3 urban), and some private practice doctors and midwives in the study areas.
2. Fifty seven (57) semi structured interviews with selected health care/family planning providers (physicians, Obgyn, and midwives) working at IPPA's clinics, urban and rural Public Health Centers and private practice doctors and midwives.

3. In-depth interviews with 35 key formal and informal leaders and policy makers at central, provincial, ad district level with the Indonesian Planned Parenthood Associate (IPPA), the National Family Planning Coordinating Board, the Ministry of Health (Directorate of Family Health Development and Directorate of Health Centers), NGOs, professional associations, women's organizations, and religious groups.
4. Focus group discussions with youth at the Lentera Youth Project in Yogya and CMM in Jakarta.

Findings of the study:

1. Level of awareness and knowledge about emergency contraceptive pills among the policy makers, program managers and health providers are still limited and also ECP as a special package is not known to most of them.

2. Many respondents still think or associate ECP as an abortifacient. This incorrect understanding in mainly because ECP is taken after sexual intercourse already happened. The need for methods like ECP is quite high among the family planning acceptors. 61.6% of OC pill users mentioned that they have ever experienced of for getting to take the pill every day. 31.3% of condom users have ever experienced condom breakage or other failure in condom use. And 32.2% injectable have ever experienced of too late re-injection for more than one week.

   There are many mis-perceptions of ECP as being used for abortion. The decision makers as well as the mothers tend to think that ECP can be used as an abortifacient, thus some of them reject the future introduction of this method.

3. After being explained about the ECP, almost all respondents agree to introduce the ECP into the family planning program. Among policy makers and program managers, out of fourteen respondents, eleven were strongly supportive. The other three have some concerns that it might wrongly accepted as abortifacient, misused or a possible set back for the program due to confusion or misperception. Among the acceptors and non acceptors respondents, all of them agree with the use of ECP after being explained of how it works. Most of them also agree to restrict it only to married couples ad not to the yours or unmarried couples.

   However, due to its potential use by youth, some of the respondents expressed their concern of its possible misuse.

4. Many respondents suggested to restrict the IEC only to eligible couples who might need it, such as the condoms and OC pill users only as a backstop. The IEC should but be given to the open public, due to its controversial issues. Some issues that need to be addresses directly in the communication strategies is a position to the use of ECP by the people who mistakenly believe the this method act as abortifacient. IEC should not directly counter the opposition to ECP, but providing the most important reasons for wide dissemination of factual information for providers and potential users. This has to be followed with good counseling and professional services.

5. Only few of all providers interviewed have ever heard of the concept of ECP. Providers from IPPA's clinics were more aware of ECP. This simply reflects the fact that IPPA's clinics have been using ECP Manual for their family planning services, which has been adopted and translated from IPPF Manual.

6. In addition, among health providers, they are also still passive in providing assistance to those who need it; they tend to suggest the clients to wait until the next menstrual period.

B.2 Discussion:

The Indonesian national family planning program quantitatively has shown a significant success. The number of active users has increased dramatically from 16 millions in 1976 to 28 millions in 1996. Despite this success, however, this program is still relied mostly on user-dependent contraceptive methods, which are rather prone for failure. The current contraceptive mix is still dominated by Pill Users (40%) , and followed by Injectable Users (36%). The former contraceptive method is totally dependent on the user in preventing the unwanted pregnancy, while the later method is affected a lot by the user's compliance of re-injection for its efficacy.

This baseline study reveals that 60.9% of Pill Users had experienced of for getting to take regular pills which can significantly increase their risk of getting unwanted pregnancy. Previous studies also found similar findings of the low compliance among Pill users, especially among those who come from low educational level. A study by PATH in 1985 has documented that more than 44% of Pill Uses did not follow instruction is using the method. Reports made by several family planning clinics in different parts of Indonesia also gave strikingly similar picture.

Injectable as the second most popular contraceptive method also prone to method failure due to incorrect user's behavior. DMPA, the most widely used injection in Indonesia, has to be re-injected every three months, with a one-week safety period. This baseline study reveals that 32.9% Injectable Users ever been late more than two weeks for re-injection. Several studies have confirmed that more than one third of Injectable Users tended to came late for re-injection. With more than tow weeks late, the efficacy of this method decrease and the users might become pregnant.

Condom, tough is still rarely used as contraceptive method in Indonesia, is gaining momentum due to extensive promotion of HIV/AIDS and STDs prevention. Among a few of Condom Users, about one third of them has experienced incorrect use which can lead to much decreased efficacy in preventing unwanted pregnancy. Moreover, the widely used traditional herbs by women at the anticipated menstrual date, suggests that the incidence of unwanted pregnancy in common , while most of the mothers prefer to get rid of it using methods familiar to the community.

Ironically, the awareness of "Emergency Contraceptives" is very low among women as the potential clients. Only 4.4% of respondents ever heard about the concept, but none have ever asked medical assistance for accidental increase of pregnancy risk. All of mothers prefer to wait until experiencing late menstrual cycle before asking medical assistance. It is very interesting the most of the sampled providers also did not know of this concept. Only those working at the IPPA's clinic manual. Most of the interviewed decision makers are also rather new with this ECP concept.

C. Conclusion and recommendations:

Pathfinder Indonesia experience very clearly identifies the importance of a base-line survey before implementation of a ECP project as lack of knowledge, misinformation regarding its mode of action particularly related to erroneous belief as an abortifacient, are a major concerns.

The fact that ECP remains so little used or understood among the providers as well as potential clients, appropriate training and IEC support are critical to the success for the introduction of ECP (mode of action and medical and technical aspects).

In order for ECP introductory trial to be delivered in the routine family planning program, the management and service delivery capabilities of program staff need to be strengthened; i.e. through training on counseling and screening, technical and use instruction as well as its differentiation from other regular contraceptive pills.

An advocacy initiative must be taken to brief the important decision makers on the accurate information, while a careful limited promotion also must be undertaken to spread accurate information to the potential users of ECP.

There was a general agreement among interviewed providers that prior to the introduction of ECP, the program should create first the community demands. This important step is absolutely needed to avoid the wasting of resources.

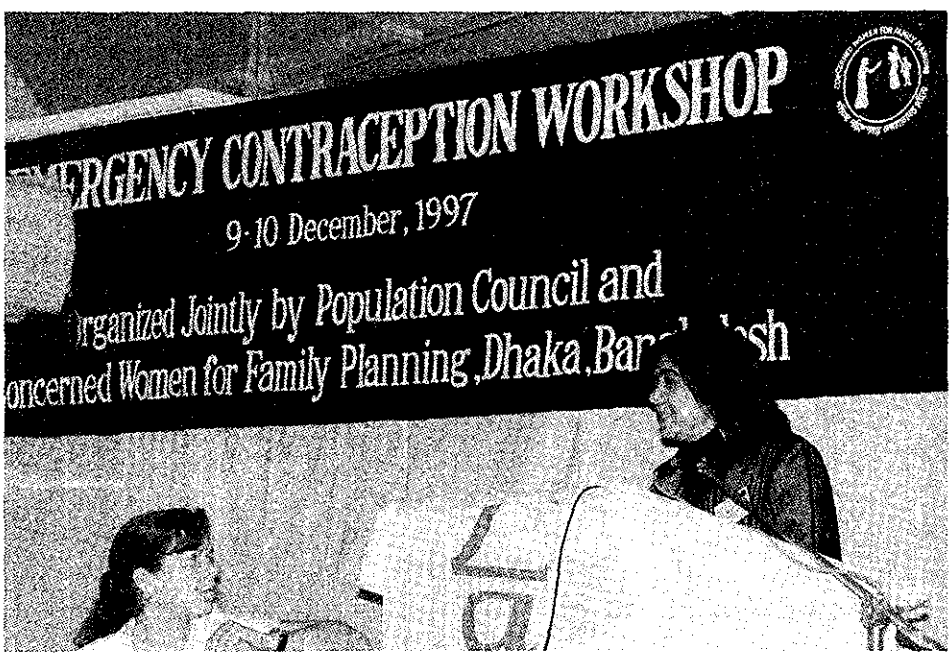
Some providers and potential clients as well as program managers mentioned that the availability of ECP will lead to irresponsible behavior among the youth. Accordingly its availability should be limited only for marriage couples and rape victims. Further, to have an impact on reducing unplanned pregnancy women need to know its availability, safety and effectiveness and detailed information and use instructions. In anticipating the potential problem of possible misuse be adolescents of ECP the ECP should be introduced through certified health facilities with well trained providers. The promotion of ECP should be limited through individual or group presentation, and avoid using mass media.

The providers need proper training in IEC, counseling, and clinical service before they can confidently provide ECP services for their clients. Practical IEC material and clinical manual must be developed for use, and must provide accurate and clear information as to the proper use of ECP.

As a new method with potential controversial issues, ECP needs a communication process that fostered dialogue with various groups and the community. Introduction efforts will be more successful when it started with overcoming possible political obstacles by organizing discussions over scientific and professional forums. Further, efforts are needed to get support from the policy makers.

Recommendations:

- Conduction of a baseline survey prior to the initiation of a ECP project is required in the country to identify factors that influence the patterns of choice and potential use
- A training program designed to encourage health providers to be more proactive in prescribing ECP wherever needed. And a technical guidelines and instructions must be made available to all trained providers.
- Appropriate IEC materials should be developed for policy makers/program managers, providers and potential clients.
- Comprehensive strategy in introducing ECP must involve national level policy makers/ planners, local community leaders, such as religious leaders, to minimize any potential opposition.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EMERGENCY CONTRACEPTION: THE NEED FOR MEDIA ADVOCACY

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Paper presented at the Workshop on Emergency Contraception
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Introduction

Increasingly, organisations and governments are realising that providing information to people in a way that they can understand and act upon is an essential part of offering quality health service. The mass media as an informant is a powerful force in our society. Its ability to influence the public agenda, and amplify and lend legitimacy to the voices of our nation's debates on important issues renders it an essential catalyst for change.

However, there are strategies through which the mass media, particularly the news media, can be used more effectively to serve the greater community interest, particularly public health. One important strategy is media advocacy. Media advocacy involves the innovative and strategic use of mass media. Media advocacy is intended to make explicit the conflict of values and the political nature of public health that colour issues such as, alcohol and drug-related problems, HIV/AIDS, violence, contraceptive methods.

Although in theory, the most commonly used method of emergency contraception, consisting solely of combined oral contraceptives taken at a higher dose over a very short period of time, is already available in most countries, this method is little used or understood. Barriers to use include: service and regulatory obstacles; the complexity of socio cultural influence; and most important, a lack of knowledge among both the users and the providers. Expanding access to emergency contraception requires a communication strategy that fosters dialogue at all levels; pays attention to the sequence of communication activities, the content of informational messages; and includes key stockholders at both planning and evaluation stages.

Media advocacy uses mass media strategically, aggressively, and effectively and can become a significant force for influencing public debate on emergency contraception. It can put pressure on key people by increasing the volume and channels presenting a public health perspective and in turn, increasing the visibility of values, people, and issues behind the voice.

This paper is about understanding the constraints under which media functions, how media advocacy can address those constraints, and why media advocacy can raise awareness levels on emergency contraception more effectively as opposed to a traditional information campaign.

The Media Connection

The rapid spread of television and radio, the rise of an independent press, and increasing literacy rates makes the mass media an increasingly powerful force in our societies (Visaria and Visaria, 1995). World-wide people look to television, radio, cinema, and print for information on health and family planning. In essence, the media provides a forum for major discussion. For health educators for HIV/AIDS across the world, Rock Hudson's (a Hollywood actor) and Magic Johnson's (famous basketball player) announcements of their HIV positive status have been important milestones. In the United States of America, Jolinson's announcement inspired more response to the Centers for Disease Control and Prevention AIDS hot line than any of the latter's prior public service advertisements on AIDS (Jorgensen, et al, 1992). Similarly in India the portrayal of a socially conscious actress to pass important messages on HIV/AIDS had more impact than slogans ever did.

But, in far more subtle ways, the mass media, and especially the news media, sets our national agenda every day. The topics journalists choose to report and the ways in which they report them, influence public discussion and private conversation. In essence a forum is created where selection, definition and discussion of public issues occur and are reported (Wallack, et al, 1993). As people are exposed to new information, ideas and values - such as the use of a post-coital contraceptive

methods or emergency contraception - many become aware and interested and eventually some decide to take action. News coverage can contribute at each stage in the process.

Understanding the Media

The forum that the media create is extremely important as individuals need access to information to make informed decisions. The media does have a legal and ethical responsibility to communicate useful information. However, though most media strives to maintain democratic ideals, it cannot remain responsive to community interests simply because of that. Mass media operates under constraints that restrict the range of actions and attitudes that it communicate. Its primary concern is to attract the largest audience possible. Moreover newsworthy events happen every day. There is a lot more potential news than television, radio or newspapers have the time or space to cover. This means a great deal of discretion in what kinds of events are covered and how they are covered. Media advocacy influences this focus.

What is Media Advocacy?

Media advocacy evolved when it was realised that other media approaches were not adequately addressing needs. The 1980's were a difficult time for many concerned with social and health issues. Across countries, community groups and local agencies, in an effort to make optimum use of the media, looked for innovative strategies. Media advocacy was one of the products that emerged.

Media advocacy is in large part, about making sure that the story gets told from a public health point of view. Its power to make a difference grows from the specific fundamental principles and values underlying it. It's purpose is to apply pressure for changes in policy to promote public health goals by using media strategically (Wallack, et al, 1993).

Understanding Media Advocacy

Similar to the news, the primary strategy of media advocacy is story telling. But unlike the news, media advocacy attempts to tell a story in a way that promotes specific outcomes. As Michael Pertshuk, one of the architects of this approach explains 'media advocacy is the strategic use of media for advancing a social or policy initiative'. There are many steps in the definition of media advocacy that Pertshuk provides. Initially, the goal of media advocacy must be determined and articulated. Then a story needs to be developed based on facts and values and made meaningful to a clearly defined audience so that it can attract attention. The general population is always a target but it is usually a secondary rather than a primary target. The primary audience will likely be a more clearly defined group of decision makers, legislators, community leaders, or community groups: Media advocacy isn't about a mass audience. It's about targeting the two or three per hundred, who will get involved and make a difference. It's about starting a chain reaction and reaching a critical mass (Public Media Center).

Having a focused story with a clear audience in mind is essential but has little value if there is no forum for getting the story out. Mass media is society's primary forum for story telling and access to this resource forms the core of media advocacy. Access means having outlets to reach the audience. These outlets include the editorial page, news coverage, public affairs, and talk shows on radio and television.

However, access is also closely guarded by the media creating an underlying tension that permeates media advocacy - the struggle to control terms of access. Media gatekeepers such as editors, journalists, and publishers might see access routes for a community agency through public affairs

time or space. They may not see the activities of the agency as interesting or newsworthy. The community agency may unwittingly reinforce this belief because of their lack of skill or experience in dealing with the media. Hence, the activities of the agency are effectively minimized, its story limited, and its access restricted. On the other hand the community group might view its activities as newsworthy and of vital community interest. By learning how to frame issues to attract media attention and not being reticent about the importance of their mission, local groups can gain access to the media. Gaining access is essential but only part of the media advocacy. Influencing how and where the story is reported is the other half.

For example during the 1980's, the women's movement in Asia began to get media attention. However stories on the early activities of the women's movement were relegated to the women's pages of the newspaper despite movement leaders' belief that their activities were hard news. The trade-off was that their stories got more inches but the audience that they wanted to reach was not the one they sought to influence. Also, by placing the news on women's movement on the segregated women's page classified those stories among, food, fashion and furnishings and not among those columns that dealt with the pressing affairs of the day.

Why Media Advocacy?

The media mainly has a **two step function**. First it selects certain people and events for attention and thus contributing to **setting the public agenda**. Second, it frames the issue telling the audience what is important to know about the story. By presenting a problem in a particular way the media may not only tell people what issue to think about but how to think about that issue.

Setting the Agenda: Given the brief attention span of the media on any particular issue, a primary task of media advocacy is to focus the spotlight on a particular issue and hold it there. Using the search light image, agenda setting means an issue is illuminated, its importance is acknowledged by the targeted audiences, and subsequently action is taken on the issue. The media advocate, here wants not only to seek media coverage, but to place the issue on the public agenda by extending the attention span of the media to increase the saliency of the topic for a given audience. The agenda-setting function is complicated for any given issue, but more so for a complex one as people have their own opinions and do a fair amount of their own filtering, amplifying, and interpreting the flow of information. Attitudes need to be addressed, especially those relating to complex issues such as sexual violence, unprotected sex, HIV/AIDS among others.

Framing the Issue: Despite ideals of objectivity, in practice the reporting, shaping, and presentation of news and information are very subjective. Everything cannot be said about every issue in every story in the short space of a newspaper article or a television broadcast. Certain things are included in the package, while others are left out for both professional and sometimes personal reasons. The selection process, what is left out and what is left in, is called framing. There are several journalistic conventions through which framing can be seen to focus on certain aspects of the issue, including the presentation of images and symbols, the use of selected spokespersons, the use of selected words and the emphasis on individual levels of problem definition. In the case of emergency contraception, framing is crucial as the focus needs to be maintained on emergency need rather than on contraception.

The evolution of HIV/AIDS on the US national media agenda from the year 1981 to 1988 highlights the important role that agenda-setting and framing can play. A number of political and personal factors slowed the emergence of AIDS on the national media agenda and then once on the media agenda, AIDS continues to have a high visibility. Surprisingly, a number of factors that did not seem important for the media-setting agenda were the actual number of cases of AIDS and the

important research findings such as HIV virus in the blood supply, heterosexual contact as a means of transmission, and the identification of the HIV virus as the cause of AIDS -- all pre-1985 events.

By themselves these events seemed newsworthy but coverage by three major television networks and the New York Times, the Los Angeles Times, and the Washington Post was limited. The reasons for this are very informative. The New York Times is a newspaper of record; this means that other newspapers take their cue from the Times. An editor for the Times felt that news stories about gays were not appropriate for the newspaper. And because AIDS was not covered there it was not deemed an important issue by other newspapers. At the national level, AIDS had two formidable barriers that kept it off the media agenda. AIDS had no human face to it and it had not been acknowledged by the President. In fact until mid-1987, news people did not ask any questions about AIDS at White House press conferences. Intense lobbying, after the announcements of Rock Hudson, Magic Johnson on the media and the focus on the 13 year old Ryan White's trauma at not being allowed to attend school as he was suffering from the disease, media reports varied from an average of 4 stories per month in the initial era (1981) to an average of 168 stories (1988). Today, the issues covered are more diversified and related to care, insurance, employment, confidentiality, and social attitudes and not just to the numbers of infected persons and transmission cases (Rogers et al, 1991).

The lessons learnt from AIDS research on agenda-setting and framing are important for any issue that is potentially controversial, has complex issues surrounding it, and where there is a lack of information. Specific lessons include the following:

- Institutional and personal variables limit media access and reportage. This is more so in cases of controversial issues and these have to be tackled by coalition building and advocacy.
- News pegs and significant events provide opportunities for an unlimited spin-off for stories and help expand the media agenda both in terms of quantity of coverage and topics which have the potential, thus making framing easier.
- Personal experience and prejudice can make a story attractive or unattractive.
- Although data are important, human face to the story or a credible spokesperson may be more important.

Fundamental Steps of Media Advocacy: As a takeoff from the main media functions, effective media advocacy includes three concrete, fundamental steps: framing for access (setting the agenda), framing for content, (shaping the debate), and advancing the policy.

- Framing for access is shaping the story to get journalists to gain access to the media. Even for social and health issues that are not new, framing for access can help in rediscovering an existing issue in a fresh way. For a relatively unknown issue, this key element can determine its worthiness.

- Framing for content is all about telling the story the way you want it to be told. An issue is framed with all its root causes and upstream conditions - that is conditions which make an issue seen as a part of a larger goal or context.

- Advancing Policy. The key goal of media advocacy is to advance policy or approaches to addressing the problem. Getting the media's attention and having the story aired or appear in print is often the easy part of the job. Work needs to be done to frame for content to articulate the solution and move the policy forward.

The Need for Media Advocacy for Emergency Contraception as Opposed to a Traditional Information Campaign

Emergency contraception has the following key characteristics which make it difficult for a traditional information strategy to work:

- Hormonal methods are not recommended for repeated emergency contraception because the doses for emergency use can cause side effects such as nausea. In addition, such methods are less effective as emergency methods than as regularly used contraceptives. For example, although combined oral contraceptives are almost 100 percent effective as a regular method of contraception, they reduce the risk of pregnancy by only about 75% when used as a method of emergency contraception.

- Contraceptive methods used for emergency situations are typically not packaged or labelled specifically for emergency use. The specialized regimens for use - related to the timing of initiation and dosage, have not been granted approval in several countries, posing both practical and political barriers.

- The different regimens for normal use of a familiar contraceptive method and for emergency use may be confusing to providers and users alike. Hence, needs to be clearly articulated.

- Using emergency contraception within the specified time period which is soon after unprotected intercourse remains critical to its effectiveness. Therefore, women need to have the knowledge about the method and the regimen in advance and must be able to access it either in advance of the need for use or upon identification of need. This may prove to be difficult in many service delivery settings.

- Some providers may restrict emergency contraception only to certain groups of women whom they consider appropriate users based on their personal beliefs or values.

- Some individuals and groups will oppose emergency contraception in the incorrect belief that it acts as an abortifacient.

Hence, the nature of the political and service delivery obstacles to expansion of access, coupled with the fact that women must have advance knowledge of emergency options present a communication challenge. For these reasons, a communication campaign for emergency contraception must pay attention to:

- the needs of the intended audiences;
- anticipated problems such as provider bias;
- the basics of good communication limitations on information, education, and communication (IEC) component of service delivery systems in the absence of a policy statement; and
- the content of key messages.

How is Media Advocacy Approach Different as Compared to a Traditional Information Campaign

- First, media advocacy as a strategy with coalition building and community organization as its base of support, provides various community groups with skills to attend to the biases, myths and misconceptions about emergency contraception. These groups become potential advocates who can use their resources, energy, and skills to promote change. This is in sharp contrast to traditional information campaigns that merely address the audience in a one-way

communication. If the audience is included in the planning at all, it is only after the parameters have already been set.

- Second, traditional forms of mass media emphasize the information gap and then health educators attempt to provide the information to fill the gap. When people have the information it is assumed that they will then act and the problem will be solved which, in fact, is not found to be the case.

- Media advocacy focuses on the power gap, viewing health problems arising from a lack of power to create social change. Hence, it highlights parallel issues, thereby attempting to motivate social and political involvement. A classic example of using the media to fill the information gap was the Partnership for a Drug Free America. This programme produced public service advertisements based on the idea that "if only people knew how bad and uncool drugs were they would not use them.' Many of these advertisements are memorable but their strong statements generally did not take a public health approach. Instead, they focused on individual behaviour and personal responsibility. These advertisements insisted that "the drug is your problem, not the government's (Blow, 1991)". If there are mitigating reasons for drug use - poverty, family turmoil, self-medication, curiosity - you would never know from the advertisements. Similarly, for emergency contraception if we create messages where the theme line is "Contact you nearest doctor' and the nearest doctor was not the target for a primary phase of the information campaign the entire purpose would be lost.

- Media advocacy also shifts the focus from changing the individual to changing the environment in which the individual acts by addressing a critical mass of people that can make the difference. It, therefore, addresses constraints such as lack of service delivery systems, provider bias, lack of quality of care, lack of confidentiality, that deter the use of emergency contraception.

- Media advocacy develops healthy public policies rather than just health messages. The policy focus reflects a long-term planning perspective for social change as compared to a short-term problems-solving approach of traditional information which pays attention only to immediate concerns. Media advocacy does address short-term pressing issues, for example, a specific advertising campaign - but only in the broader context of overall policy development and change. For emergency contraception media advocacy can help focus attention on the absence of a policy statement and help in the development of a supportive policy.

- Finally, media advocacy moves the focus for media access from the public affairs desk to the news desk. The idea is to present issues in a way that are newsworthy; are of high level interest to the public; and have direct links to community well being. Rather than being supplicants for public time, media advocates present themselves as partners in the news-making and news-gathering process. By having various experts assist the media in framing messages we can ensure that the information on emergency contraception is factually correct, unbiased, and provides the right perspective.

Using Media Advocacy to Increase Access to Emergency Contraception in India

In India, the Population Council has recently initiated a media advocacy project on emergency contraception. We have adopted a three-phased strategy that begins conservatively in order to build strong support and partnerships, but is designed to eventually fill in the gaps in information about emergency contraception and reach a wide audience.

Phase 1: Coalition Building and Baseline Research

The first phase of our project aims to build critical support for emergency contraception among important constituencies including policy makers, women's health advocates, and the general media by:

Coalition Building

Coalition building will involve formal networking with groups of selected policy makers, service providers, women's health advocates, media and personnel to ensure support for emergency contraception and also for our media efforts. This will also allow us to identify individuals and groups who may present obstacles to our efforts, as well as those who may eventually play prominent roles in supporting our effort - by either becoming media advocates or spokespersons on emergency contraception.

We plan to organize meetings to provide information to selected individuals about emergency contraception as well as our media advocacy efforts. Small discussion exercises will enable participants to think through many of the social and sexuality issues surrounding use of emergency contraception and will also assist us in refining our campaign messages.

Baseline research

As there is a paucity of specific data in India on emergency contraception which is an essential requirement, we propose to obtain our media campaign data on potential provider and user information and attitudes about emergency contraception through focus group discussions with university students and family planning clients, and by administering a short questionnaire on emergency contraception to providers attending health-training sessions.

Thus, in this first phase of the project, we will gather data from providers and users on their knowledge and attitude about emergency contraception. These data will be used for our media campaign.

Phase 2: Media Campaign

Working with individuals identified through our coalition building efforts and by using results from our baseline research, in the second and main phase of our project, we will develop a series of print, audio and video public service announcements on emergency contraception. Each medium would be identified to reach a specific audience. For example editorial and health pages in leading newspapers, and advertorials and articles in medical journals and women's magazines would be used. We propose to organize news programmes, public affairs shows, talk shows and sometimes even paid advertisements in the electronic media. We also propose to include articles in selected language newspapers, television and radio to ensure a wide reach in rural areas. We hope that the number of newspapers, magazines, radio and television stations which run our spots and carry our articles will increase dramatically once the campaign is launched.

Phase 3: Evaluation

In the final phase, we will evaluate our media campaign. Through our proposed media campaign, we seek to raise awareness and to establish a niche in a client-centred reproductive health program, among the public about emergency contraception. In evaluating our campaign, therefore, we will try to answer some key questions such as: *How willing was the media to pick up these spots? Who was reached (demographic information about audiences)? What actions did the messages help*

inspire? What were the perceivable consequences for the service sector? What lessons can be drawn from working with the media to develop these social issue materials?

Concluding Comments

The important work of media advocacy is really done in the planning stage before the campaign is launched. There has to be a prior knowledge of how the approach is to be advanced, symbols used, linkages of symbols to the issues, the voices that need to be provided and the messages that have to be communicated. The issue can be re-explored in terms of media opportunities. Strategies can then be developed to frame for access and for content in the media. Framing for access and framing for content force us to think in terms of the media and its needs.

To make emergency contraception available to women who want it, the number of providers who are knowledgeable about it must be increased. Political and regulatory obstacles need to be overcome; and emergency contraception should be available at an affordable cost and at the time when women need it. Women who may require emergency contraceptive services need to be made aware of their availability and where they can be obtained. Media advocacy is a part of a strategy to exert pressure on those whose decisions influence the policy environment. It is a strategy that supports the development of healthy public policy as it combines the innovative use of media and advocacy initiatives which include coalition building, development of effective spokespersons, and extensive public participation.

Finally, it is important to understand that the goal of advocacy is not just media coverage but policy change; that media advocacy is but a tool - albeit a very important one; and that the media can be effectively used as an integral part of a more comprehensive advocacy program.

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3.8

NEEDS FOR EMERGENCY CONTRACEPTION : EXPERIENCES FROM THE COMMUNITY

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Paper presented at the Workshop on Emergency Contraception
Dhaka, Bangladesh
December 9-10, 1997

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Organized Jointly
Concerned Women for F

Concerned Women for Family Planning (CWFP) began as a small-scale, experimental project for household family planning (FP) information, motivation, counseling and distribution of oral contraceptives and condoms in 1976 with a total staff of five women field workers working with a population of approximately 50,000 in Dhaka city. Over the decades, range of services rendered by CWFP expanded largely, incorporating Maternal and Child Health (MCH) services and services for males in 1994.

At present, the organization operates through the following divisions, namely,

- Clinic based services
- Training
- Women's Development
- Finance and Administration
- Management Information System
- Operations Research.

Objective of the paper :

The purpose of this paper is to share the years of experiences of CWFP in the Family Planning (FP) field. By reviewing the problems in terms of contraceptive users and factor for non-use and there by knowing about the conditions arise for being pregnant unintentionally through the different events of life, an effort is made to suggest groups who are in need of emergency contraceptive.

Methodology :

Information was collected through discussion with a group of field workers and paramedics who worked in Family Planning Maternal and Child Health (FP-MCH) project of CWFP for several years. The field workers in Family Planning project of CWFP were involved in family planning motivation, education and distribution of pills and condoms at household level and the paramedics provided IUD, injectable, norplant through clinical services.

The key topics of the discussion were their practical field experiences about the factors responsible for the misuse of different family planning methods, social conditions for non-use of a method and the consequences of these. They were also requested to narrate any sexual incidents e.g. sexual violence of our society. Also a few cases were studied who wanted to prevent pregnancy even though they were susceptible to unprotected sexual activities. These cases were listed as eligible couples of CWFP's Lalbagh area.

Selection criteria of the cases :

1. Had an accident in contraceptive use.
2. Had unprotected Sex.

Results :

Problem in relation to contraceptive use :

The workers of FP project mentioned that many women using oral contraceptives (OCs) have experienced unprotected intercourse. The most common reasons behind this even as they stated are women using oral contraceptives commonly forget to take their pills, or start a cycle of pills too late or too early. Although these mishaps occur mainly among the new acceptors of pill, in each case

they are placed at risk of pregnancy. A most common problem the field workers faced with the clients as they stated is like this :

"Emphasize was always given on the counseling about the proper way of use but there are many clients who believe that OC can use only when they have a sexual act." And this misconception results in an unscientific and self made procedure of taking pill.

However, messages were always conveyed by our FP workers to women about the consequences of improper use of family planning methods, still, a proportion of problems arise among the OC users which is mainly associated to younger age and new clients. They also mentioned that when low dose OC was first introduced, the clients faced severe spotting and intermenstrual bleeding which were causes for improper use of low dose OCs and the workers observed many unplanned pregnancies at the time of introduction of low dose OCs. But in course of time these clients became more manageable and prevalence of these mishaps gradually decreased.

The FP workers were asked about the common mishap occurs among condom users. Our field experiences showed that even among the couples who use condoms consistently and correctly, experiences of breakage of condom is not uncommon. and another accident they often experience is condom slippage. The most common reasons for the occurrence of unprotected sex in case of condom users, as stated by the workers :

"Initial acceptance of condom is good but in course of time the male counterpart become unwilling to use condoms as itching arise and also as it interferes in gaining highest pleasure during sexual act".

Other types of contraceptive failure are also observed by the FP workers which include dislodged norplant, partial expulsion of IUD, missed date of injection, who have recently switched from other methods (principally OC) to condom etc.

The risk of unintended pregnancy results most frequently who practice the natural method like safe period and withdrawal. The reasons behind this as they mentioned are :

"They never encourage the practice of safe period neither withdrawal system, because their assumption is that it's not possible for the illiterate people of our country to calculate the safe period or to practice the withdrawal method properly. Miscalculation is a common event among the natural method users.

Another even of the society is that a women often get victimized by her husband after a misunderstanding or argument between them. The husband forces the women to have unprotected sex as a form of punishment or revenge. Later, they realize the consequences of the mishap.

Practical Experiences of Social Conditions for Unprotected Sex :

Even though, the contraceptive prevalence rate in Bangladesh has increased to several folds, a large proportion of eligible couple are still behind the use of mordenized FP methods. From the statement of the FP workers, we came to know about the typical obstacles to use of contraceptives which include, fears that long-term use of a method is harmful to health, on the other hand, many women lack control over their reproductive choices, and the belief that FP is against the religion. Contraceptives are readily available to every group through this field level workers and they also indicated that these groups are also willing to protect them from unwanted pregnancies.

The workers in the field of family planning have specially highlighted the issue of newly wed couple who are embedded in a certain cultural norms which prevent them from their innate ability to act as an individual. In Bangladesh nearly 50 percent of 15 to 19 years old girls are married. In Bangladesh, where girls as young as 13 years old are married, 80 percent have had a birth by age 20[1] We have learn from our grass-root workers that this young group of girls face sexual coercion within marriage and , strong pressure from the family to have children early to prove their fertility. The workers also described them as a potential group who are willing to practice FP methods. But being surrounded by in-laws who restrict use of FP methods, it is not possible for a girl aged 13 or 15 years to prevent her unintended pregnancy. They stated,

"Even they want to practice regular modern FP methods secretly, but it is quite impossible as the in-laws' are such evil they follow her every steps in life".

Unintended pregnancy risk are becoming pronounced in women who have infrequent intercourse. This may result from extramarital or premarital relationship, sexual violence or abuse and mobile occupation of their husband. Since the workers were responsible to visit the selected communities for several years, they were ask to give some examples of this type of secrete event, but the workers failed to give a clear picture about the prevalence of this events. But anecdotal examples (not experienced directly) shed some lights on the occurrence of this relationship. This is a group who are in high risk of unintended pregnancy as this situation is a hidden secret and due to the unprepared sudden sexual act they are not able to practice regular FP methods.

Consequences of Unprotected Sex :

Each and every group (i.e. The people who have method failure or are not using any methods) may have experienced an unprotected sex. And this unprotected sex may result in unwanted pregnancy, which may end in abortion, miscarriage or birth. Although many of them do not experienced an unwanted pregnancy but fear may arise among them from being pregnant. The workers were asked to specify the out come of unprotected sex among the people of their working areas. They could clearly define the outcome only in case of FP method users. Majority of the clients desired to terminate their unplanned pregnancy (if they got pregnant) through abortion.

The women in the urban areas are more or less aware about the MR services existing inside the country, so for any missed period of menstruation they sought MR in hospitals. But there is a proportion who came to know about their unintended pregnancy beyond the time frame of MR and this group was determine to terminate their unplanned pregnancy by any means. Majority of them went under unsafe traditional methods, which might have lead to death or given rise to serious morbid condition. And there was another group of women chose to carry their unintended pregnancy to term.

Case History

A. Switch over to Condom.

Name	**:**	**Shakila**
Age	**:**	**Don't Know**
Duration of marriage	**:**	**14 years**
Parity	**:**	**6**

She usually practiced oral contraceptive pills. But when she switched over to condom, she became pregnant which she did not want which resulted in the birth of a girl child. She could not remember the time of mishap which resulted in the unwanted event.

B. Improper Use of Pill

1.	**Name**	:	**Badsha Jadi**
	Age	:	**37 years**
	Duration of marriage	:	**15 years**
	Parity	:	**3**

She is the women who directed her contraceptive use procedure according to her own choice. Due to improper use of oral pill she experienced unwanted pregnancy once in life and the outcome of this pregnancy was still birth. At the time of delivery the mother was in a critical condition.

2.	**Name**	:	**Surjamala**
	Age	:	**35**
	Duration of marriage	:	**12 years**
	Parity	:	**4**

She was a pill user. She missed pill for several days which resulted in pregnancy

3.	**Name**	:	**Kanchan Mala**
	Age	:	**Don't know**
	Duration of marriage	:	**20 years**
	Parity	:	**5**

After having five children she started taking pill, due to mistake in pill use she became pregnant. She decided to have MR done.

4.	**Name**	:	**Rowshan**
	Age	:	**40 years**
	Duration of marriage	:	**16 years**
	Parity	:	**4**

She used pill, forgot to take pill for one or two days and became pregnant. When she became aware about her pregnancy she went to the doctor for abortion service but the doctor did not perform the abortion. Thus she finally gave birth to a baby.

C. Social Barrier

Name	:	**Hasna**
Age	:	**22 years**
Duration of marriage	:	**4 years**
Parity	:	**1**

She could not adopt any family planning method. But she was afraid of getting pregnant again as her child is only 2 years old.

D. Condom Failure

1.	**Name**	:	**Monowara**
	Age	:	**Don't know**
	Duration of marriage	:	**16 - 17 years**
	Parity	:	**5**

Her husband uses condom as a preventive measure but he is not satisfied and does not use condom regularly. She is in fear of getting pregnant any time but she is not willing to use a female method regularly.

2.	**Name**	**:**	**Najma**
	Age	**:**	**Around 40 years**
	Duration of marriage	**:**	**22 years**
	Parity	**:**	**6**

Her husband uses condom. She became pregnant due to a condom rupture. She attempted abortion though traditional process i.e. Kabiraji medicine but the method failed and pregnancy continued with a live birth.

All these cases are knowledgeable about FP methods, their proper use, steps needed for improper use. The reasons of these unavoidable situations are lack of caution and literacy of clients and may be as a result of midcycle unprotected sex.

❖ ***The names of the clients have been altered to maintain privacy.***

Discussion :

Every couple has a right to have a sexual act free from fear of being pregnant. It is not unlikely in a country like Bangladesh where majority of the population are illiterate to have a mishap and occurrence of unintended pregnancy is not an uncommon event even among those who use barrier methods. In developing countries thousands of women experienced unwanted pregnancies and an estimated 70,000 to 200,000 women die each year from complications related to unsafe abortion[2]. Unsafe abortion leave hundreds of thousands more with long term health problems, including infertility[3]. In Bangladesh the Maternal Mortality Rate is around 5 per 1000 live birth[4]. Though estimated statistics cannot be given but through reviewing this paper it can be seen that unintended pregnancy ended in serious consequences which include induced abortion or birth.

A pregnancy puts women at risk of morbidity and mortality. A number of women sought MR, as highlighted by the FP workers, which is entailing high cost to the patient and the government and, women attending any surgical procedure like MR may also suffer from significant morbidity. Those whose unwanted pregnancies result into full term birth also increase the risk of maternal mortality and morbidity and give rise to population explosion in a country like Bangladesh. The use of emergency contraception may be increased if this women knew about such a procedure.

From our field experience it is obvious that a large proportion of women do not want to or cannot practice regular method due to fear of discomfort with side effects and also due to restriction of family members. But they also intend to prevent their unwanted pregnancies. These pictures emphasize the special need of emergency contraceptive for women in our country to avoid unwanted pregnancy that lead to birth, abortion. But doubts arises about these later two groups ,to what extent they can get benefit from emergency contraceptives.

Though the picture of sexual violence and abuse is hazy, in a rapidly changing conditions these problems are also emerging as a concerning problem. Emergency contraception can also be associated with the rape victims.

But before introducing emergency contraceptive in a wide range, research about emergency contraception specially on clinical trials, need assessment, service delivery is warranted. Special emphasis should be given for its investment in comprehensive FP services.

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3.9

EMERGENCY CONTRACEPTION ENHANCING WOMAN'S CHOICE FOR PREVENTION OF UNWANTED PREGNANCIES IN BANGLADESH

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December 9-10, 1997

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Introduction

As more and more countries are moving forward towards establishment of successful family planning programs, the issue of emergency contraception is coming more to the forefront. Although emergency contraception has been practiced since time immemorial, it is only recently that the need for a systematized approach to the issue of provision of emergency contraception has been taken up by family planning programs in many countries. In fact this can be considered to be normal progression in the development of family planning. During the initial phase of development of such programs world-wide, we have seen an emphasis on 'quantity'- i.e. an emphasis on developing infrastructures, ensuring supply, creating demand. As programs mature, the emphasis shifts to 'quality'. It is at this phase that the needs of special groups begin to be identified and addressed.

Choices available in emergency contraception are unfortunately quite limited. The Yuzpe regimen of using standard dose combined oral contraceptive pills remain the most used and prescribed method. Progestin only pills, of which one brand, Postinor, has been marketed only on a limited scale in Bangladesh recently, is gradually gaining popularity. Danazol, a synthetic androgen is also used, as is RU486 and IUD inserted post-coitally.

The above methods each has its own disadvantage. Complicated regimes, which require application/intake after specific intervals (e.g. in case of pills), side effects (after pills or Danazol) and limited availability or non-availability in case of Bangladesh, of other methods (Progestin only pills, RU-486) make the effective use of these methods difficult. As a result, the choice becomes, in effect, even more limited.

Unplanned pregnancies in Bangladesh

In Bangladesh, it is estimated that 33% of all births are unplanned. Of these, 13% are unwanted and 20% are mis-timed. If we add to proportion the numbers of menstrual regulation procedures and the backstreet abortions, we come up with a startling figure of 45% of unplanned pregnancies (Singh et al, International Family Planning Perspectives, September 1997)!

How do Bangladeshi women respond to an unplanned pregnancy? From my experience as a reproductive health service provider, and before that as a researcher in this area, the overwhelming reaction I have come across, in most cases, is a resignation to fate. Since most of the unwanted pregnancies happen among married women, the sense of desperation is less, particularly since in many families children are considered to be 'blessing from God' or 'assurance of old age support'. We have anecdotal evidence to suggest that some women, particularly in urban areas do try emergency contraception, combined pills in most cases, though the proper regime is apparently not known to many of the users.

In this circumstance, we find that a large number of women resort to either MR or clandestine abortion procedures. It is logical to assume that women with the information of MR do first turn up for an MR procedure. In fact, a medium estimate of the number of Mrs. performed annually in Bangladesh is 730,000. However, in the absence of specific knowledge, about 1/3 of MR clients are rejected, since they turn up too late (BAPSA, 1996). Most of these late comers along with those who don't have any information on MR usually end up with traditional/non-medical abortion providers. The result: about 262,000 backstreet abortions, 20% ending up in a hospital with abortion related complications.

Emergency contraception: choice for women in Bangladesh

As I have said before, the choice of Bangladeshi women for emergency contraception is very limited, most women relying on combined oral contraceptive pills. We discussed the use of these pills among 31 continuing users in two of our clinics. While about 60% of these women knew that these pills can be used for emergency contraception, only 6 women could correctly identify the Yuzpe regime. Among these only one woman actually knew that the regime applies to standard dose formulations only. In this backdrop it is easy to imagine the effectiveness of these pills in emergency contraception.

Postinor, a Progestin only pill has only recently been marketed. A quick survey of 24 shops around the Elephant Road/Shahbagh area of Dhaka city revealed that only 2 shops sold 'Postinor'. The drug was available over the counter, and no instruction were given while dispensing. Although the package insert has quite complete information on the drug and its use, unfortunately, we had reasons to suspect that shops were selling single or two or more tablets, cutting them off the strip.

The way forward

The above picture clearly indicates the need for more detailed planning and thinking about emergency contraception. First of all, there is the need for a **definite policy** for emergency contraception. This policy would need to be developed with the participation and consensus of all major stake holders- the policy makers, program implementors, donors and most importantly the potential users of emergency contraception. The policy should clearly indicate the role envisaged for emergency contraception. The policy will need to boldly address the most important debate in the area of emergency contraception- whether emergency contraception will detract from regular contraception.

Improved marketing will be the key to proper promotion of emergency contraception. The basic questions of marketing- range of products, prices, place of availability and a position for emergency contraceptive vis-à-vis other contraceptives will need to be clearly identified, preferably through country specific needs assessment research. Once decisions are taken in these areas, the challenge will then be to design an effective marketing strategy which will ensure proper demand.

But perhaps the most immediate step needed now is to start working towards development of a supportive environment for emergency contraception. Already, the concept of emergency contraception suffers from a certain level of mistrust. This mistrust, perhaps evident most strongly, associates emergency contraception with irresponsible sexual behavior. Thus there is the need to build up a true image of the concept among providers as well as potential users. Realistically, there will be a thin line between 'use' and 'abuse' of emergency contraception. And how successful we are in building the initial awareness about emergency contraception will decide how frequently we will have to cross the line in future.

3.10

EMERGENCY CONTRACEPTION: EXPERIENCES FROM VIETNAM

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Dhaka, Bangladesh
December 9-10, 1997

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December, 1997
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Vietnam is one of the developing country in the world , Population growth remains the primary interest and worry among workers in the area of population and Family Planning. The current growth rate of the Vietnamese population is 2.1%. The percentage of married couples applying modern contraception is 53%.

In Vietnam, the most common contraceptive method is IUD and the second most commonly used is the condom. The use of Oral contraception accounts for 6% to 7% and sterilization 2%-3%. Ninety percent of the total population live in several areas. They have low level education and very little access to information sources and exposure to the world outside their farming land. Poor understanding of the users about contraception and limited out-reach of public propaganda on various contraceptive methods both result in the currently high abortion rate.
Every year there are about 2 million abortions against 1.7 million deliveries. In Hanoi and Ho Chi Minh particularly the rate is approximately 3.2. The government has undertaken steps to decrease the number of abortions. The diversification of and the change in the pattern of contraceptive methods reflects initial progresses in Vietnam. However, there are still some contraceptive methods which are considered new to the Vietnamese people including emergency contraception.
Neither extensive training for health workers in the family planning system on emergency contraceptives nor official researches on the use of the method have been conducted in the country.
A recent study conducted by Nguyen Thi Nhu Ngoc of Hung Vuong Obstetrics - Gynecology Hospital in HCMC provides some reflections on the awareness about Emergency contraception among health workers in Ho Chi Minh city includinand the shortage of proper knowledge and information about the method.

SURVEY OF NGUYEN THI NHU NGOC

The interviews were conducted in December, 1995 and March, 1996 and took place at 9 representative hospitals of the total 18 in and around the HCMC. A total of 99 participants were selected, out of which 66 were Medical doctors and 33 were nurses and midwives.

Findings:

- All participants except for those from 1 rural site had heard of or used Postinor .
- Participants of 7 of the sites were, familiar with some version of the Yuzpe regimen.
- Participants of 7 of the sites knew about the Emergency use of IUD.
- Participants in half of the focus group mentioned vaginal douching, as an effective Emergency contraceptive.

In only 1 group was this assertion rebutted .

In addition, they received some answers which reflected the poor understanding of the interviewees. When interviewed, some health workers thought spermicidal jelly was an emergency contraceptive. Some others mentioned Cao ich mau (an herbal remedy for delayed menses) and drinking large quantities of coconut juice as an emergency contraception.

One said Mifepristone (known to her as RU 486) was also an emergency contraception.
A similar situation can be found in most parts of the country including Hanoi. In the last 1 year, the MCH/FP center of Hanoi has introduced emergency contraception as a part of the training curriculum to grassroots health workers. We have not yet been able to introduce and familiarize the method to a wide range of users. However, we have instead conducted a minor research in an effort to assess at what level the clients understand about the various contraceptive methods, including emergency contraceptive method.
The research started in January 1997 and will be finished in December 1999.

- Progress schedule
- Phase 1 : from Jan. to Sep. 97

We interviewed women clients visiting health clinics for family planning services or abortions. The questions we raised covered such issues as: present and past experiences in applying contraceptive methods, reasons for failures during active use of contraceptives, level of understanding, knowledge and actual use of emergency contraception.

Table 1 : **Age distribution of respondents**

Age	No.	%
<20	8	0.8
20-29	344	34.4
30-39	515	51.5
>40	133	13.3
Total	1,000	100.0

The average age is: 29.6

Most of the clients who had abortions fell under the age group of 20 to 39, which we consider as the target to address in Stage 2.

Table 2 : **Educational Background**

Educational Background	No.	%
Primary School	32	3.2
Lower Secondary	345	34.5
Higher Secondary	436	43.6
College/University	187	18.7
Total	1,000	100.0

The most common educational background was Lower-Secondary School and Higher-Secondary School (78.1%). The fact suggests that we design IEC curriculum to provide in Stage 2 knowledge appropriate to their respective educational level.

Table 3 : **Number of abortion experiences**

Number of abortion experiences	No.	%
0	195	19.5
1	414	41.4
2	286	28.6
>3	105	10.5
Total	1,000	100.0

The majority of the clients previously had abortions (80.6%), 10.6% of which having 3 and more. This reflects the ineffective use of contraceptive methods.

Table 4 : **Current Use of Contraception**

Number of interviewees having used	No.	%
IUD	480	48.0
Condom	220	22.0
Pill	92	9.2
Injectable	9	0.9
Norplant	1	0.1
Sterilization	1	0.1
Traditional Methods	197	19.7

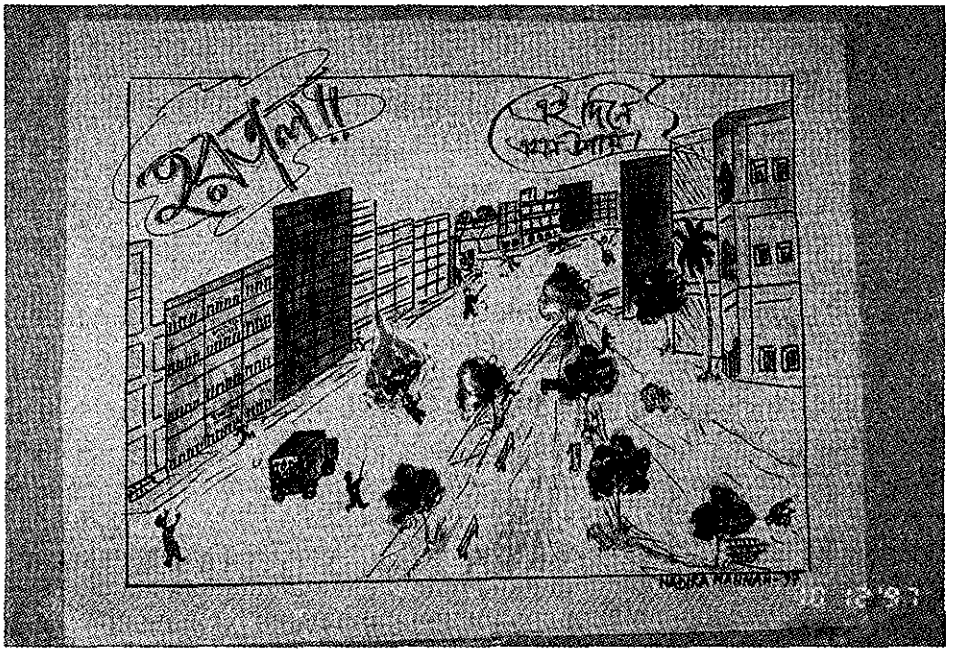
The, rate of clients experiencing unwanted pregnancies while using IUD, condoms and other traditional methods was high, which recommends us a review over the information and instructions on the use, of each particular methods.

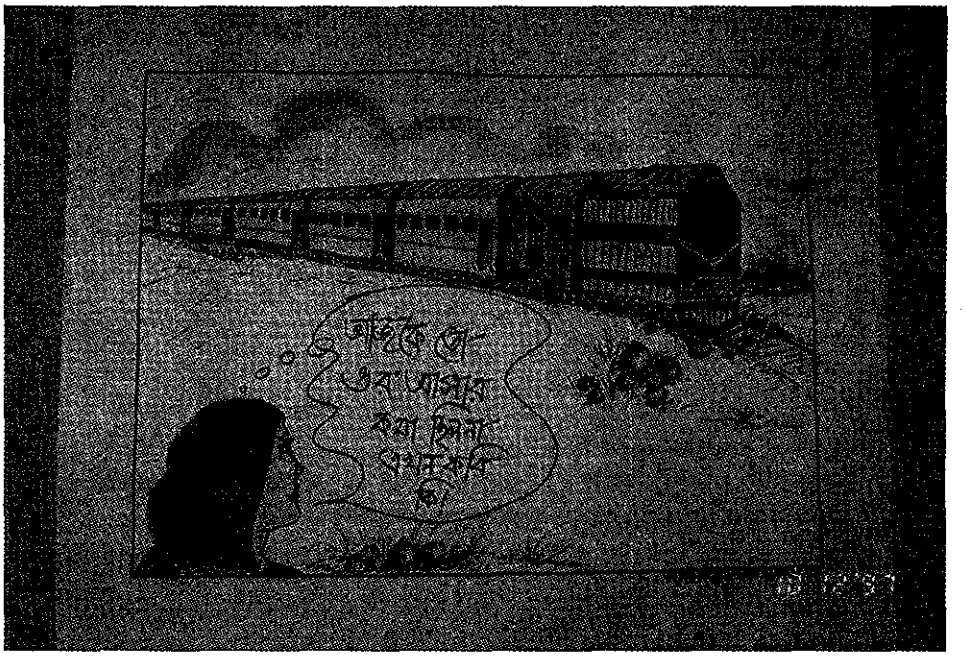
When asked if they knew about Emergency contraception, 3.0 percent of the interviewees said yes. However, 40 percent of this group (12 women) did not understand correctly about Emergency contraception. They assumed that, MR was an Emergency contraception. When asked about how to use it, only 0.3 percent were able to give the right answers. All of these three clients were government employees who had tertiary and college education.

In terms of the, source of information, they reported they had learnt from their friends and health workers. All these clients, however, said the information they received was little and not very specific. When asked if they found it necessary having more information about Emergency contraception as many as 965 (96.5%) respondents responded affirmatively while others (mainly farmers) did not find it necessary since they had quite a few alternatives.

When asked from whom they felt most confident and comfortable to receive information and contraceptives 72.1 percent said from health workers, 21.7 percent from population activists, another 2.7 percent from the office where they work and the remaining 3.5 percent from chemists. Most of the women interviewed found information provided by health workers reliable and they preferred getting contraceptive methods from them as well. On the other hand, the study by Nguyen Thi Nhu Ngoc showed inadequate knowledge of health workers. In that sense, the provision of proper knowledge about emergency contraception for health workers would be a definite need and should be realized soon. 82.0 percent of the respondents said they never knew where to go for emergency contraception, 14.5 percent assumed chemists' and the rest (3.5%) municipal hospital. In fact, only two of them had used Postinor bought from the chemists.

We can not yet in a position to organize specialized training on emergency contraception and popularize the method widely. In fact, the training we have done just spared a small space for emergency contraception so that the information provided is not yet complete and comprehensive as expected. In addition, we ourselves have never been able to attend any formal training particularly on this method. The matter of financial constraint remains another big challenge to our work. Never the less, we are committed to exert our efforts to put Emergency contraception into use as another common contraceptive, method in Vietnam.





3.11

KNOWLEDGE, ATTITUDE AND PRACTICES ON EMERGENCY CONTRACEPTION AMONG SELECTIVE HEALTH CARE PROVIDERS AND DRUG SELLERS IN DHAKA CITY

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Background:

Emergency contraception are methods that can be used by women to prevent pregnancy after an unprotected intercourse or contraceptive failure. Methods that are currently viable in the system such as oral pill, IUD can be used as an emergency methods by women are exposed to sex with out any contraceptive protection or where contraceptive have failed such as condom rupture, missing pills, dislodged IUD. However the concept has never been highlighted as a need for any. Bangladesh family planning program is known as success story for its commendable progress and current choices available are better than some other country in the region. In the post ICPD era program planners , policy makers donors and NGOs are looking at ways and means improve the program further as par recommendation in the ICPD program of action :

Program must enable couples and individuals to decide freely and responsibly the number and spacing of their children, to have information and means to do so, to ensure informed choices and to make available full range of safe and effective methods.....

In Bangladesh major thrust of the FP program has been on methods that needed to be used on a continuous basis. The concept of emergency contraception is relatively new in Bangladesh. Despite availability of the methods that can be used as emergency contraception there has been very little effort to offer women with emergency contraception as a choice to prevent unwanted or mistimed pregnancies. Very recently a brand of emergency contraception "Postinor" has been marketed by the private sector and made available through pharmacies without proper IEC activities .

Although 49 percent women are currently contracepting we must acknowledge that there is still an unmet need especially among newly weds, adolescents, and for women who are in prolonged separation, living away from their spouse who often do not adopt a continuous method. These factors along with women's lack of reproductive awareness and power in sexual decision making results in unplanned pregnancies and abortions. The only option for those who do not want to continue the pregnancies undertake life threatening measures to terminate the pregnancies. In such a scenario emergency contraception can be a valuable reproductive health option. It should also an essential part of treatment of women who are victims of sexual assault.

Objectives:

1. To determine the current level of knowledge, attitude and practices on emergency contraception among doctors.
2. To determine the level of knowledge, attitude and experiences on Postinor among drug sellers.

Methodology:

A sample of 64 doctors were selected from GoB facility, Private clinics, NGO clinics and General practitioners practicing in the pharmacies. Doctors were given self administered questionnaire which they filled out in the presence of the field investigator.

Pharmacies were selected from different locations of Dhaka city and in each location five pharmacies were visited. A total of 30 sales person were interviewed by the field investigator using a semi structured questionnaire. Duration of data collection was two months.

Literature Review:

Emergency contraception although first used in the 1960s, after four decades it still remains a largely unknown method. A variety of hormonal contraceptives (high doses of ordinary birth control pills, high doses of mini pills, Progesterone only preparations) and copper intra-uterine device (IUD), Danazol, RU 486 have been identified as emergency contraception.

Administration of 100 mg of ethinyl estradiol and 0.5 mg of Levonorgestrel taken within 72 hours of unprotected sex and repeated 12 hours later; alternatively, 0.75 mg of Levonorgestrel administered within 48 hours and repeated 12 hours later can be used (*Blaney CL)*. The Yuzpe method involves ingestion of 2 tablets, each containing 50 mg ethinyl estradiol and 500 mg norgestrel, within 72 hours of unprotected intercourse, followed by 2 more tablets 12 hours later. If taken after ovulation, the pills make the endometrium unsuitable for implantation of a fertilized egg and change the corpus luteum function. If taken during the first half of the cycle, they delay ovulation (*Kubba A*). The Yuzpe regimen was commonly known as "**the morning after pill**". Insertion of IUD 5-7 days after the event has been found to be 99 percent effective in preventing pregnancy (*Kestelman P)*. IUD has two mechanisms of actions; it creates a foreign body response and a blasto-cytotoxic effect, both of which inhibit implantation. A single dose of 600 mg of RU-486 or "**French abortion pill"** is the another method, which can be given on the last three days of each cycle. If fertilization had occurred RU-486 would prevent ovum from implanting ; if not, the drug would merely induce menstruation within 48 hours.

In August-September 1988 in Tower Hamlets Health Authority London, 88 abortion clients were surveyed regarding their knowledge of postcoital contraception. Sixty five percent had heard of the "**morning after pill**", but of these only 19 percent knew of the 72-hour time limit. Nine percent thought the time limit was earlier. Examples of confusion over the popular name included: Two women thought it was a pill to be taken "*the morning after*" one woman said it was taken every morning; another thought it was for morning sickness; three women believed it was to be used only in case of rape- not for "*ordinary women*" one thought it was illegal. Four women stated that they had thought of using it, but did not know the time limit. Eighty one percent said that they would have used postcoital contraception if they had known about it. The study strongly suggested that a public information campaign for clients, general practitioners, medical students, nurses and teachers be set up, and that the name of postcoital contraception be changed to "**emergency contraception**" *(Burton R. et.al)*.

Emergency Contraception are available in the United Kingdom, the Netherlands, Malaysia, China, Mexico, and Nigeria since the late 1960s and early 1970s. The level of availability and use of postcoital, or emergency, contraception vary widely depending upon the prevailing relevant regulations and policies, providers' and women's understanding of and attitudes toward it, and cost. At present in the Netherlands and the UK, postcoital contraception is an accepted and important part of family planning practice, well-known among both physicians and women at large. In Malaysia, where abortion is strictly regulated, emergency contraceptive methods are marketed legally, but family planning organizations avoid offering them. In China, emergency contraception has long been offered by the government family planning service, but they have not been separated into methods advocated for emergency use only and those recommended for ongoing use. In Mexico and Nigeria, awareness of emergency contraception remains low among both health care providers and the public (*Glasier A et, al.)*.

During the 20 years of ECP use, no deaths, serious medical complications, fetal malformations, or congenital defects have been reported (*Pathfinder International* and *Emergency Contraception Hotline*). The most common side effects of ECPs are nausea and vomiting.

However in most parts of the world women and even health care providers worldwide do not know that contraception following intercourse is feasible or readily available, few products are specifically marketed for emergency contraceptive use, and service providers are often reluctant to provide emergency methods. Many family planning providers do not offer emergency contraception. Numerous providers do not have adequate knowledge of emergency contraception. (*Family Health International [FHI]; World Health Organization [WHO]; International Planned Parenthood Federation [IPPF]; Population Council).*

In New South Wales, Australia, 76 urban general practitioners (GPs) and 84 rural GPs completed a questionnaire designed to determine their knowledge, attitude, and prescribing practices concerning emergency contraception. Rural GPs were more likely to know about emergency contraception than urban GPs (95 percent vs. 78 percent). Yet urban GPs were more likely than rural GPs to receive many requests for emergency contraception and to prescribe it often. Female GPs not only were more likely than male GPs to know about emergency contraception but also to prescribe it. Fifty eight percent of urban GPs and 52 percent of rural GPs prescribed the Yuzpe regimen (100 mcg ethinyl estradiol + 500 mcg Levonorgestrel within 72 hours of unprotected intercourse and repeated 12 hours later). Sixteen percent of both groups always included emergency contraception in discussions about contraceptive options. Eighteen percent only provided this information on request. Sixty percent of all GPs would provide information about emergency contraception as a back-up to barrier methods (*Weisberg E et, al.).*

In 1993, 294 US health care providers completed a questionnaire, designed to determine how frequently they prescribe emergency contraception. These practitioners included obstetrician-Gynecologists (OB-GYNs), family practitioners, nurse practitioners, physician assistants, nurse-midwives, and emergency physicians. This group prescribed emergency hormonal contraception a total of 1009 times in the last 12 months for a mean of 3.4 prescriptions/professional. Thirty one percent of all such prescriptions were for rape victims. More than 66 percent of prescriptions for rape victims were written by emergency physicians. OB-GYNs were the most likely group to have ever prescribed hormonal emergency contraception and to have prescribed it within the last 12 months while family practitioners were the least likely group to do both. Only 8 practitioners inserted an IUD for emergency contraception (15 insertions). Around 90 percent never or rarely discussed emergency contraception with their patients. Just 10 percent had literature on emergency contraception available. About 66 percent of those who had no literature were interested in having this literature available for patients (*Grossman RA et, al.).*

In the US, more widespread use of emergency contraception has been hindered by equation of the method with abortion, the mis-perception that pills must be taken the morning after unprotected sex, lack of staff training, lack of consumer awareness of its availability and source, concerns women will substitute the method for consistent contraceptive use, and the lack of any formulation specifically marketed for this purpose.

A survey was conducted in Britain by Crosier among 1354 women aged 16-49 years to assess the levels of knowledge, awareness, and use of emergency contraception. The author found that there was very little spontaneous awareness among the women of the term "**emergency contraception**." Less than 25 percent were able to say accurately how long emergency contraceptive pills could be used following unprotected sex or contraceptive failure. Forty percent of those women aware of emergency contraception reported having first heard of it from leaflets, books, or magazine articles. Only 14 percent had heard of it from a doctor or other health professional, while 12 percent of respondents reported having used emergency contraception at some time. Almost 50 percent of this latter subgroup reported some level of dissatisfaction with the service they were offered *(Crosier A).*

About 50 percent of all pregnancies in the UK are unplanned. More than 170,000 pregnancies/year are terminated. About 25 percent of 25 year olds have had an abortion. Contraceptive failure is responsible for almost 50 percent of unwanted pregnancies. About 70 percent of unwanted pregnancies can be predicted because women know that they are at risk after unplanned intercourse or an accident with a condom. Emergency contraception would prevent pregnancy in 98 percent of these cases. Reasons for non-use include denial of pregnancy risk, not knowing where to get emergency contraception, and physicians control of access to it. Other obstacles are, it is embarrassing to explain to a receptionist why an emergency visit with the physician is needed and family planning clinics do not provide services seven days a week. Women may receive emergency contraception in emergency rooms, but staff are not best equipped to counsel about sexual behavior (*Drife JO*).

The April 1995 Bellagio Conference on Emergency Contraception was sponsored by South to South Cooperation in Reproductive Health, Family Health International, the International Planned Parenthood Federation, Population Council, and the World Health Organization with the support of the Rockefeller Foundation. Twenty four experts who met at the conference argued that millions of unwanted pregnancies could be averted if emergency contraception were widely available (*Family Health International [FHI]; World Health Organization [WHO]; International Planned Parenthood Federation [IPPF]; Population Council).*

Four sets of recommendations were proposed on Methods, Policies and Regulations, IEC/Advocacy Service Delivery:

"(1) Methods of emergency contraception should be effective, safe, convenient to use and easily accessible. Ethinyl estradiol/dl-norgestrel combination oral contraceptives and the copper intrauterine device (IUD) best meet these requirements. However, experts recommended additional research to develop new methods. Anti-progestogens appear very promising for emergency use. (2) Intergovernmental agencies, governments, and non-governmental organizations (NGOs) should ensure that emergency contraceptives are included in all family planning programs and on all national essential drug lists. Drug regulatory authorities should require explicit description of emergency use in the labeling of ethinyl-estradiol/dl-norgestrel oral contraceptives and for the copper IUD. (3) Activities should be developed among women's groups, professional associations, health advocates, policy makers, NGOs, donors, and community leaders. IEC strategies should consider groups such as adolescents. (4) Emergency contraception should be made available to all women who seek it, provided no contraindications are present. In order to prevent pregnancy following acts of sexual violence and coercion, emergency contraception should also be available from sexually transmitted disease clinics, rape crisis center's, police stations and hospitals. Training in emergency contraception should be included in the curricula of all medical and non-medical personnel. Women seeking emergency contraception should be offered reliable methods of contraception. In consultations women should be provided with emergency contraceptives for future use. Hormonal emergency contraception is appropriate for distribution through clinics, over-the-counter in pharmacies, and community-based programs. Research should be conducted on innovative service delivery options. Data should be collected on emergency contraceptive use (Berer M et, al.)."

Findings From The Survey of Doctors

Background Information of the Respondents

Table 1 : Summary Table		
	Respondents	**Percent**
Place of work	**N=64**	
GoB Facility	22	34.4
Private Organization	15	23.4
NGO Clinic	12	18.8
Only General Practice	15	23.4
Years of Experience	**N=64**	
Less than 1 year	2	3.1
1-3 years	13	20.3
3-5 years	7	10.9
5-10 years	11	17.2
10 years and above	31	48.4
Type of training on FP *(Multiple answers)*	**N=35**	
MR training	16	45.7
Sterilization/NSV/Ligation	14	40.0
Norplant training	7	20.0
Training on IUCD	2	5.7
Training on Oral pill	1	2.9
Did not disclose	1	2.9

Out of the 64 respondents 34 percent worked in the GoB facility, 23 percent were from private clinics and 23.4 percent were from NGOs. Forty eight percent of the doctors had work experience of 10 years and above, 31 percent had work experience between 1-5 years and only 3 percent had experience less than one year.

28 percent had post graduate training. Fifty four percent of the doctors mentioned that they had received some training on FP which mostly includes sterilization and Norplant and MR.

Family Planning Consultation

Table 2 : Family Planning Services Offered by the Respondents		
FP Services/Consultation Offered	**(N=64)**	**Percent**
Yes	**61**	**95**
Oral Pill	55	85.9
Condom	50	78.1
IUCD	40	62.5
Sterilization	34	53.1
Injection	31	48.4
Postinor	9	14.1
Traditional Method	6	9.4
No/Not Applicable	3	4.6

Multiple Answers Possible

All the doctors were asked about whether they provided any family planning services to their clients and 95 percent responded that they did provide family planning consultation. Most commonly offered methods were pill (85.9%), condom (78.1%), IUD (62.5%), and sterilization (53.1%). Fourteen percent offered Postinor and nine percent advised on traditional method.

Awareness on Emergency Contraception

Table 3 : Awareness of the Respondents in Emergency Contraception		
Information	**Respondents**	**Percent**
Heard/read about emergency contraception	**N=56**	87.5
When Heard/Read		
1-4 years back	34	60.7
5-9 "	13	23.2
10-14 "	5	8.9
15-20 "	4	7.1
Where Heard/Read		
Book/Journal/Newspaper	46	82.1
Some place	6	10.7
Medical Representative	2	3.6
Other Doctors	1	1.8
Did not specify	1	1.8

Eighty seven percent (56) of the doctors responded that they heard/read about emergency contraception/morning after pills/post coital contraceptives. Only 9 percent did not hear about it. Eighty two percent of the doctors learned about emergency contraception through journals, books and newspapers and only 3.6 percent learnt from the medical representatives. It is important to mention here that medical representatives of Medimpex are the only information providers on Postinor at present.

Knowledge About Emergency Contraceptive Methods

Table 4 : Respondents Knowledge on Emergency Contraceptive Methods		
Types They Knew	**N=47**	**Percent**
Postinor	31	65.9
Oral Contraceptives	24	51.1
IUCD	19	40.4
Cumarit Simplex/Methergin/Menstrogen		
Primolut N/Others	11	23.4
Condom	2	4.3
RU 486	1	2.1

Multiple Answers Possible

When asked to name some emergency contraceptive methods 73 percent of the clients could mention name of some emergency contraception method and the most commonly mentioned methods were Postinor (65.9%), Oral pill (51.1%) and IUD (40.4%). About 23 percent mentioned other hormonal preparations like Menstrogen, Primolut N, Cumerit Simplex and Ergometrine and 4.3 percent (2) mentioned Condom as emergency contraceptive method. Only 1 doctor mentioned about RU-486. Regarding availability 39 percent (25) mentioned Postinor, 35.9 percent (23)

mentioned oral pill. IUD was mentioned by 27 percent (17) and other hormonal preparations were mentioned by 17 percent (11).

Table 5 : Respondents Knowledge About Postinor		
What it is	**N=64**	**Percent**
Post-coital pill	11	17.2
Levonorgestrel/Progesterone Tablet	9	14.1
Low dose oral pill/Combination pill	6	9.4
Others	6	9.4
Used before intercourse	1	1.6
Did not specify	32	50.0

As Postinor has been marketed as emergency contraception the respondents were asked about what type of preparation Postinor was. 50 percent of the doctors interviewed did not know what type preparation was Postinor. Only 17.2 percent mentioned it was post coital contraceptive method, 14 percent mentioned it was progesterone and 9.4 percent mentioned it as a combination pill.

Table 6 : Respondents Knowledge About Indications of Emergency Contraception		
Indications	**Number (N=48)**	**Percent**
Unprotected Sex	23	47.9
For Rape Victims	16	33.3
Rupture of Condom	13	27.1
Pre-marital/Extra-marital/Casual/Incidental	10	20.8
Sex Traditional Method Failure	4	8.3
Newly Wed Couples/After Akth	2	4.2
Others	15	31.3

Multiple Answers Possible

Seventy five percent of the doctors responded on the indications of emergency contraception and the most commonly mentioned indications were unprotected sex (47.9%) Casual sex (20.8%), rupture of condom (27.1%) and for rape victims (33.3%). Only four percent (2) mentioned newly wed couples and eight percent quoted traditional method failure respectively.

Table 7 : Respondents Knowledge About Side Effects For Emergency Contraception		
Side effects	**Respondents (N=28)**	**Percent**
Nausea and Vomiting	13	46.4
Bleeding, Spotting etc.	10	35.7
Vertigo, Headache and Dizziness	9	32.1
Congenital malformation	4	14.3
Incomplete Abortion	3	10.7
Ectopic Pregnancy	2	7.1
Breast tenderness	1	3.6
Could not specify	3	10.7

Multiple Answers Possible

Regarding side effects doctors have some correct and some incorrect knowledge. Nausea and Vomiting (46.4%), Bleeding/spotting (35.7%), Headache and Dizziness (32.1%) were the most commonly mentioned side effects. However 14.3 percent mentioned Congenital malformation and 10.7 percent mentioned incomplete abortion as the most common side effects.

Table 8 : Respondents Knowledge about Contraindications of Emergency Contraception		
Contra-indications	**Respondents (N=18)**	**Percent**
Systemic Diseases/Thromboembolizm/CVA	8	44.4
Jaundice	6	33.3
Bleeding/Anemia	6	33.3
After Defined Time Limit	2	11.1
PID	1	5.6
From repeated use	1	5.6
Could not specify	4	22.2

Multiple Answers Possible

Only 28 percent (18) doctors mentioned that there are some contraindication of EC and the most commonly mentioned contraindications were, Systemic disease (44%), Jaundice (33%), Bleeding disorder/Anemia (33%). Eleven percent mentioned use after defined time limit i.e. 72 hours after unprotected sex as a contraindication. A small proportion mentioned repeated use (5.6%) and PID (5.6%). However 22 percent could not mention any specific contraindications for emergency contraceptives.

Table 9 : Respondents Opinion About The Need of Emergency Contraception in Bangladesh		
The Reasons	**Respondents (N=58)**	**Percent**
For population control	12	20.7
To avoid unwanted pregnancy/ reduction of MR	10	17.2
As backup service to FP methods	10	17.2
For rape victims	8	13.8
For prolonged separation	6	10.3
For extra/pre marital sex	2	3.4
Could not specify	4	6.9

Multiple Answers Possible

Eighty seven percent believed that there is a need for emergency contraception in Bangladesh. Of them 20.7 percent thought that it would help in population control, 17.2 percent said that it could help in avoiding unwanted pregnancies or MRs, 13.8 percent suggested that rape victims could benefit from it and 10.3 percent mentioned that EC would be useful for partners separated from each other for a prolonged period.

Attitude and Practice of Emergency Contraception

Table 10 : Information on the preparations they had prescribed				
Preparations	**Correct**	**Partial Correct**	**Incorrect**	**No Answer/DK**
Postinor/Morning After Pill	6	4	3	9
IUD	-	1	-	9
OCP	-	4	2	9
Others	-	1	2	8

37 percent (24) responded that they have prescribed emergency contraception in the month preceding the survey, of which 54 percent (13) prescribed Postinor, 25 percent (6) prescribed oral pill and only 12.5 percent (3). Those who prescribed Postinor only 6 of them could prescribe it

correctly in terms of timing dose and frequency. Out of six doctors who prescribed oral pill only 4 prescribed it correctly. Only one doctor mentioned about post coital use of IUD.

According to the respondents married women and women using condoms were the most common client category and 14 percent mentioned women staying away from their partners and 10.9 percent mentioned young unmarried girls. Forty two percent of the respondents mentioned that women themselves come to them for this services and 18.8 percent mentioned both men and women seek emergency contraception service.

Among those who reported prescribing emergency contraception in the past month majority mentioned that they observe repeated use among their clients. As the sample size was very small this issue needs to be explored further.

Table 11 : Opinion on Providing ECs in Advance or When Needed

	(N= 64)	Percent
In advance	26	40. 6
Only when needed	27	42.2
Did not specify	11	17.2

Almost 41 percent of the doctors opined on providing emergency contraception to women in advance, of which 57 percent felt that advanced prescription is needed because of sudden visit of the spouse and during strike. Eight percent thought it is necessary for newlywed couples to have this sort of contraceptive methods available in advance. Only four percent opined that ECs should be available to women in advance to prevent tension and anxiety in case of unplanned and unprotected sex.

Table 12: Respondents Opinion on the Availability of EC Directly from Pharmacies

	Respondents	Percent
Whether should be available directly	N=64	
Yes	30	46.9
No	34	53.1
Why not?	**N=34**	
Since there may be misuse	15	44.1
Lack of pharmacists knowledge on EC	7	20.6
May increase sex crime	4	11.8
For examination/screening of patient	3	8.8
Others	1	2.9
Could not specify	8	23.5

Multiple Answers Possible

When asked whether emergency contraceptives should be available to women directly from pharmacies, more than half of the respondents opined that it should not. Describing the reasons, about 44 percent mentioned that there would be misuse and nearly 20 percent were concerned about the lack of knowledge of the pharmacists on emergency contraception. Moreover, approximately one fifth of the respondents expressed their concern that free access of such methods may influence people to indulge in free sex.

FINDINGS FROM THE SURVEY WITH DRUG SELLERS

The Emergency Contraception Survey was conducted through interview of 30 drug sellers from pharmacies of 12 areas of Dhaka city (namely Jatrabari, Saidabad, Chankarpul, Gulistan, Maghbazar, Malibagh, Kawranbazar, Mohammadpur, Shyamoli, Lalmatia, Dhanmondi and Mirpur). The major findings are as follows.

Background Characteristics of the Respondents

Table 13: Background Characteristics of the Respondents

Background	Respondents (N=30)
Age of Respondents	
20-24	7
25-29	7
30-34	9
35-39	3
40+	4
Level of Education	
Primary	2
Secondary	12
Higher Secondary and Above	16
Institutional Training on Pharmacy	
Yes	10
No	20

The age of most respondents were below 30 years (14). About one third (9) belonged to the age group 30-34. The respondent's literacy level was quite impressive. More than half (16) were found to have completed higher secondary level and even further education. 12 respondents completed Secondary level and only 2 completed primary level of study. Nearly two third of the drug-sellers (20) had no training on pharmacy. The rest (10) had some institutional training.

Knowledge and Practice on Postinor

All the respondents had heard about Postinor. About half (15) sold on an average 1-2 packets per week. 6 sold about a packet a month and nearly one quarter could sell around 3-5 packets in a week. Only one had been able to sell about 5 packets and above per week.

Table 14: Summary Table on Knowledge	
Knowledge on Postinor	**Respondents (N=30)**
Whether the Drug-Sellers heard about Postinor	
Yes	30
No	0
Whether they sell Postinor	
Yes	30
No	0
The average sale of the drug	
1-2 packets a week	15
3-5 packets a week	7
About a packet a month	6
5 and above packets a week	1
None so far	1
Type of Preparation	
Birth control pill for women	22
Birth control pill	7
Cannot tell clearly	1
Mechanism of Action	
Controls birth (usable even after intercourse)	18
Controls birth (nothing else known)	12
Is there any other kind of preparation as like Postinor?	
Yes	0
No	30

When asked what kind of preparation Postinor is, nearly three fourth (22) specified it as a birth control pill for women. Among them, 2 enumerated the drug as birth control pills for women to take within 1 hour of intercourse *(Mohilader jonno jonmo niontroner bori, ja shohobasher ek ghontar modhay khete hoy)* 7 answered that it was just a birth control pill, not specifying who should take it. When asked how Postinor works more than half (18) of the respondents answered that it worked for birth control and destroyed child bearing power *(Shontan dharon khomota dhonsho koray)*. 12 specified that it worked as a birth control pill after intercourse. None had heard or knew of any other kind of preparation like Postinor.

Table 15: Buyers' Characteristics	
Characteristics	**N=30**
Age	
20-29	6
30-39	21
40+	3
Class	
Middle	23
Upper	7
Sex	
Male	27
Female	3

According to the drug sellers, most of the buyers are males (90%). Only three stated that they had female customers. Nearly four fifth (23) confirmed that the middle class people were mostly the customers of Postinor; only about one fourth mentioned upper class customers as users of Postinor. None had buyers from the lower class. Besides these, three said that unmarried youths are also the frequent buyers; one mentioned that newlywed couples also bought such a drug. Affirmed by the respondents, two third of the buyers were between 30-39 age and one fifth belonged to the age group 20-29. Only three reported to have customers of age 40 years or above.

About 90 percent (26) mentioned that they knew why people were buying Postinor. Among them, 15 said that people bought it for birth control purposes in post coital action. seven specified that they came to buy•Postinor because the customer forgot to take any other method before intercourse. four stated that people buy this drug since it is easier to use and less troublesome than other birth control methods.

17 reported that buyers wanted to know about this drug from them. Ten mentioned that whenever customers want to know anything, they advice them to look up the attached leaflet in the packet. One of the respondents advises his buyers to take one tablet after intercourse (interestingly, he also advised his client to have sex 4 times a month). One suggests his customer to take one pill within 24 hours of intercourse while one recommends the buyers to take within 1 hour of intercourse. In addition to these answers, one drug seller advocates his buyers to take 1 hour after having sex and that one tablet has 8 hours maximum capacity. Another two recommend to take 4 pills in a month. Only three drug sellers reported that people using Postinor had come with post usage problems. Among them, one said that users have vomiting tendency, one stated that most of the time menstruation starts immediately after use and one mentioned that menstruation became irregular after usage of Postinor.

Table 16: Summary Table on Practice	
	N=30
Reasons for buying Postinor	
For birth control in post intercourse action	15
Was easier and more convenient than other methods	7
Clients forgot to take any method before intercourse	4
Did not know	4
Type of information given on Postinor	
To use as per leaflet within the packet	10
To use not more than 4 times in a month	4
To use within 24 hours of intercourse	1
To use within 8 hours of intercourse	1
To use within 1 hour of intercourse	1
Buyers do not want to know about the drug	13
Problems mentioned by buyers from using Postinor	
User feels nauseated	1
Menstruation starts after each use	1
Irregular menstruation after use	1
No clients come with problems	27
Remedial advice given for side effects	
To stop using Postinor	1
To use just after menstruation	1
To use 1 hour before intercourse	1
No clients come with problems	27
Drug-sellers suggestion on the frequency of Postinor use	All answered that it should be used 4 times a month

When asked what advice they gave for solving such problems-----one drug seller quoted that he reassured his customers that at first such things will happen, but later it will be all right-----the remaining two respondents said they advised their customers to stop using Postinor.

Nearly 63 percent (19) suggested their clients to use the drug within 1 hour after intercourse and four of them recommend to use Postinor 1 hour before intercourse. One even advised his customers to apply the drug from the beginning of the menstruation. Two counsel the buyers of the drug to use it 30 minutes before intercourse and the same number suggested their clients to take the pill 30 minutes after having sex.

Conclusion: The survey highlights the need for further in-depth study on the issue. Though it is not possible to draw any conclusion from the small scale survey, it emphasizes the need for a large scale study to understand the nature and magnitude of the knowledge gap, attitude and practices of different level of health providers. Such information will enable program manager to design and implement strategies for the successful introduction of emergency contraception in Bangladesh.

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DISCUSSION

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4.1 SESSION DISCUSSION

The presentation sessions were followed by interactive and flourishing discussion sessions in which the discussants pointed out the following topics:

Media Advocacy

An important consensus arising at the session discussions is that information about emergency contraception should be widely spread through media advocacy.

It was also emphasized that media advocacy and individual counseling would play an important role to raise the awareness about emergency contraception since the general mass will be able to use them with more responsibility. As a result the chance of substitution of regular methods will lower.

Participants wanted to know about the possible implication of wide-spread media publicity regarding emergency contraception since many people in Bangladesh would see it as an invitation towards morality loss. In response the presenters supported media advocacy as an approach through which coalition building should be started. In this approach, the first phase will be to get informal base-line research through which attitudes and fears of audiences on this subject can be known. Thus a perfect campaign can be designed by giving emphasis on the fears of the audiences. Another important part of such approaches is that the targeted audiences are parallelly involved in the campaign right from the beginning. Those who oppose this approach should be descriptively explained about the eventual goals and include them also in the network. In this way the opposition also can have a clear and definite picture of what is going on and they themselves will understand their needs and fears.

Discussion took place regarding the means of approaching the critical mass and the providers. The presenters suggested that interpersonal as well as direct mailing of questionnaires could be a very effective form of communication since both these methods are one kind of mass media. And then as a follow-up of their replies their needs and fears could be identified. On speaking about approaching providers, one of the presenters shared the experience in India where Population Council has a program called 'Expanded Contraceptive Choice' through which the providers are reached and also an advocacy program, 'Advocacy for Reproductive Health' in India and in both programs workshops have been arranged where the providers were mainly targeted.

Emergency Contraception Options

On the subject of RU-486 as an emergency contraception option, it was mentioned that the drug has multiple properties. It acts as a daily contraceptive pill, an emergency contraception or as an abortificient. As it is a widely known abortion method and, moreover, since other emergency contraception methods available are available, effective and cheap, it is quite premature to develop it as an emergency contraception. There is very little research and policy efforts to work on RU-486 as an emergency contraception.

Debate arose on the use of IUD as an emergency contraception when a presenter quoted that IUD should not be used, as it leads to abortion if a case of pregnancy has already been established. On the other hand, some participants indicated that IUD could be used safely if a pregnancy test is performed prior to insertion.
Since Postinor was one of the more available emergency contraception's in Bangladesh, queries on this specific method were expected. Specially, the discussants wanted to know about the dose and

type of this particular method. One of the presenters explained that actually at first, there was Postinor 10, containing 10 tablets. But later as people found it difficult to take 10 tablets, the packaging was altered and changed into Postinor containing 4 tablets.

Related Issues of Emergency Contraception Use

Participants wanted to know about the frequency of use of emergency contraception. A presenter informed that emergency contraception must not be used more than 4 times in a month. Because, a research has indicated that using emergency contraception more that 4 times a month causes hormonal imbalance and in USA only 5 percent use emergency contraception not more than twice a year.

Since the risk of pregnancy is highest during the unsafe period of a women, participants wanted to know whether or not emergency contraception should be advocated only after unprotected sex during this particular period. The presenters informed not to emphasize much on the use of emergency contraception during midcycle intercourse. Then the providers may bear the failure of emergency contraception always in mind and a large number of the acceptors will be refused by the providers. emergency contraception must be readily available whenever it is necessary.

Some of the discussants raised the question about irregular menstruation while using emergency contraception. They also suggested that the instructions to be given in this perspective should be quite clear. Answering their query, one of the presenters said that, when a women takes 4 tablets within 24 hours, it will cause withdrawal bleeding. This bleeding may occur within the menstrual cycle. But if there is no bleeding, she should wait at least for 2 weeks after the regular menstruation cycle for the confirmation of pregnancy.

On the subject of emergency contraception failure, the presenters and learned discussants arrived at a consensus that there is a chance of getting pregnant which is unwanted and that measures for this unintended pregnancy is difficult. They also stressed the preparation and introduction of specific guidelines with the inclusion of probability of getting pregnant if it is taken after 72 hours of unprotected sex.

Ethical issues

Ethical issues were also discussed in concern with the service providers side when emergency contraception fails in situations or places where abortion is illegal. The participants also expressed their concern that in a country where abortion is restricted, there may be an ethical obligation to suggest abortion in case of failure of emergency contraception. In response to this regard, a presenter pointed out that though abortion is restricted in many countries, if pregnancy yet occurs even after use of emergency contraception, a woman can continue the pregnancy, as studies have shown that emergency contraception causes no harm to a once established pregnancy.

Male Involvement

Debate arose on the issue of male responsibility in family planning since in Bangladesh the male contraceptive user rate is very low. The main reasons in terms of low rate of male users is lack of communication with males. The discussants pointed out that in Bangladesh little or no interest is given to male. All over the country females are recruited as field workers and moreover the service providers have clear bias towards female. One other problem stated by the concerned discussants was that these females do not even like to discuss male methods. They suggested that if male community level workers are involved in male motivation, it would definitely make up for the existing crisis. The participants opined that if both male and female have equal accessibility to FP

method, male participation rate can be increased. One presenter gave emphasis on the communication between couples themselves. Among some other important issues recognized by a participant was that the education level is higher for man and as they go outside home more than women this group can be easily motivated by printed materials. But to reach out to them no special program is currently visible. She recommended that conjugal life will be a path of partnership and the male counterpart should share each and every burden of life.

Also in the discussion, the participants expressed their concern that if emergency contraception's are readily available, the male counterparts, who are already not willingly using condoms will probably increase their already high discontinuation rate of condom. Besides, husbands who stay away from their wives and visit home infrequently are risk groups for STDs. They were also concerned that the promotion of emergency contraception may well have a negative impact on STD prevention, because then the group at risk will not be willing to use condoms if emergency contraception is easily available.

Use as Backup Method

The participants concluded that emergency contraception should never be used as a primary method. On the contrary, it should be considered only as a back-up method. Majority of the participants came to a consensus that if emergency contraception is integrated in the regular FP program and it's use expands in a wide range, there may be a chance of substitution to regular FP method. One of Population Council's international participants gave a description about a study conducted by Population Council in India in relation to this issue. In this study two women's groups were included who are using any barrier methods. One group of them received information on emergency contraception, while to another group, four sets of emergency contraception were handed over along with the regular FP methods. One of the most interesting findings of this study was that, though the study population were aware about emergency contraception, they never tried to substitute it to regular methods.

Emergency Contraception And Unplanned Pregnancy

Questions arising about the high unplanned pregnancy rate among the current FP method users were resolved by one presenter stating that as majority of the clients usually use pills, misuse of pill is commonest and since people obtain their FP method from shops rather than service providers - improper use is quite at length and that is why the high rate of unplanned pregnancy arose among the current users.

4.2 GROUP DISCUSSION

4.2.1 Group-I : Viable Choices of Emergency Contraceptive Pills

The group expressed their opinion about the choices of emergency contraception appropriate for Bangladesh, availability and acceptability, research, program and policy issues.

Choices of emergency contraception appropriate for Bangladesh

The group recommended that there are three regimens that are currently appropriate, which are,

- **Standard Oral Contraceptives (Yuzpe Regimen).** They felt that this would be better if it is repackaged to make more convenient for women and providers. But even it is not repackaged it will be okay to use low dose and high dose combined oral contraceptives as emergency contraception provided the right number of tablets could be given (if 4+4 low dose, or if 2+2 high dose).

- **Levonorgestrel.** The group felt that the Levonorgestrel regimen (Postinor as a common regimen) is also suitable as an emergency contraception rather than an ongoing method, which is currently marketed.

- **Copper IUD.** They also opined that Copper IUD should be made available as emergency contraception only as a last resort. This would be for women who show up too late for the regular hormonal methods of emergency contraception or, for women who want an IUD for ongoing use.

The group did not feel that the other methods such as Danazol, RU-486 are ready to be recommended for the use in Bangladesh. At present, they felt that further research is needed on these methods.

Availability in Bangladesh

Low Dose Pills
- These are widely available;
- Can be used as emergency contraception with two doses required. Each dose will comprise of 4 tablets

Suggestion: To enhance availability through Social Marketing Companies and NGOs etc.

High Dose Oral Pills
- These are currently being phased out, but
- Can be used as emergency contraception with two doses required. Each dose will comprise of 2 tablets.

Suggestion: They should be repackaged specially for emergency contraception, and should be sold more frequently by the drug-sellers over-the-counter.

Levonorgestrel

- These are not available in the form of minipills
- Postinor is available through some physicians

Suggestion: Re-label Postinor so as to make it more widely available. Also make minipills available for lactating women.

Copper IUD (Cu200+CT-380)

- These are widely available in the national program but not in the private sector.

Suggestion: This should be available only for women who are appropriate candidates for emergency use of IUDs. But, it should not be a front-line therapy at all. It should not be given in cases where there is of risk of STDs.

The group also specified that, with respect to availability, all of the appropriate emergency contraceptive methods should be available in MR clinics, through drug sellers and through all other medical providers via government as well as private sectors.

Acceptability and Research

The group felt that some research is required on acceptability of methods. They felt that

- Data should be collected from users and providers in Bangladesh and other countries. The studies that are available on this topic should be shared so that women, providers and policy makers can assess the acceptability before original data has been collected
- They also pointed the important role of media to make emergency contraception more widely known and to explore parameters of acceptability
- They stressed on conducting clinical research to determine whether a single dose regimen will be possible which would be more convenient for women, simplifying the instructions. And also whether it is possible to extend the use of emergency contraception from 72 hours after unprotected intercourse for those women traveling and who are residing in rural areas
- This could be done by making regimens more accessible to the expected users
- It was also felt that study should be undertaken to assess the impact of emergency contraception on other methods since making this method available may affect the women's propensity to use other methods

Program Issues

- Inform men about emergency contraception properly
- Counsel men to use condoms, and to use emergency contraception only as an emergency backup
- Educate the drug sellers, pharmacists and other providers (*suggestion: manufacturers could help with this responsibility*)
- Clearly and prominently label emergency contraceptives that they are not for pregnancy termination
- Avoid giving the impression that emergency contraception is dangerous
- Train the trainers properly, then spread training to all providers - even at the grassroots level (*suggestion: NIPORT can do this for GoB, NGOs and others*)
- Incorporate information in all curricula and develop appropriate technical standards (government norms) and guidelines
- Women's groups, youth groups and NGOs can take responsibility for advocacy and in awareness raising
- Organize workshops for NGOs and community leaders

Policy Issues

- Emergency contraception should be available to whoever is in need of it
- Introduce emergency contraception through the national program besides other channels(SMC, NGOs and the private sector) (*suggestion: initiate the process right now*)
- Include emergency contraception in the essential services package

4.2.2 Group-II : Service Delivery Issues

The group gave recommendation on policy issues, providers need, channels of distribution, logistics, IEC, training and research need concerning service delivery of emergency contraception.

Policy Issues

This group thought about policy issues firstly, along with other relevant events. They suggested that introduction of EC should be under definite guidelines and it should be approved by the National Technical Committee. Government policy should include the clinical guidelines, information guidelines, procurement distribution reporting and monitoring guidelines as well. EC should not substitute regular contraceptive use. This should be priced and preferably higher than the regular contraceptives. In case of combined oral pills, these should be repackaged and branded. This group thought about some brand names like ***Shomadhan*** and ***Mukti***.

The Providers

ECs should be provided by all level of providers including physicians, counselors, family welfare assistants, medical assistants and all level of health and family planning workers and the pharmacists. And these should be over the counter.

Channels

Existing government channels should be used and utilized. Yearly requirement of pills are 65m cycles for regular use and that is the amount which is required now. 15% of that comes roughly to 10 million for complications and 5% more comes nearly to 5 million for EC. One cycle for regular contraceptives will serve 5 women. For Postinor it should be left for the private sector. There should be some involvement of SMC in procurement distribution marketing and also monitoring.

Logistics

The government should primarily initiate EC campaign and secondarily the private sector.

Information

Information should be provided to every one. It should be done through inter-personal communication and all sorts of media, both printed as well as electronic, and non-users should be covered as well. The government should play a very important role in demand creation.

Training

For training, ECP training should be included in basic and all refresher training courses. It should be included in all curricula. orientation to support groups like women's groups and civil societies. Orientation should be provided to men - specially the migrant workers and so on. The special groups, the vulnerable groups, adolescents and sex workers should also be provided.

The Research Issues

RU 486 as emergency contraceptives should be researched and there can be a clinical trial. There may be shift in method mix. They also suggested proper research on the prices and the impact of EC on MR.

4.2.3 Group-III : Advocacy and IEC

The group on advocacy and IEC highlighted the objectives, strategies, research and policy issues relating to advocacy and IEC on emergency contraception.

Objectives

Group-III pointed out the following objectives:

Broad Objectives:

To raise awareness level on ECP.

Specific Objectives:

- To develop supportive policies
- To formulate service guidelines e.g. accessibility, confidentiality, counseling and QOC
- To enhance capacity building and training
- To provide knowledge and assist in using services

Key Issues

The key issues that have been pointed out by the group are as follows:

- The needs of intended audiences
- Anticipated problems, such as provider bias
- Limitations of IEC component of a service delivery system
- The content of key messages which need to be audience specific

Target Audience

Research shows that awareness level is very low at all levels such as policy makers, service providers and users. Hence advocacy and IEC would target all these levels.

Strategies

Advocacy

There should be interaction with the policy-makers, health advocators, media, union leaders (that means starting from our religious leaders, community leaders) and also the family leaders (father-in-law, mother-in-law, husband) as well as decision-makers and community. The community should participate themselves in this thing.

IEC

In IEC there is a multi-approach: individual interaction and collective like group discussion, meeting, training, counseling, workshop, seminar and media strategy. To develop appropriate materials which are relevant in all situations and sensitive to needs of specific audiences.

Steps To Be Followed

The group suggested the following steps to be followed:

- Need assessment
- Involvement of the audience in development process. The audience means service-providers, users and community leaders
- Developing materials
- Pretesting of these materials
- Actual development
- Post-testing
- Review of the materials on that basis and modification; and then
- Evaluation of the materials

Research

The group indicated the following research needed to be done:

- There is a need of research on knowledge, behavioral aspect and attitude
- There is a need of research on service-providers' attitude
- There should be rapid assessment
- The findings of the research should be shared with all the audiences

Policy Issues

The government should develop an EC campaign or provide support to relative organizations.

4.3 PANEL DISCUSSION

The panel discussion was the final episode of the two day long workshop. There were in total, five panelists comprising of a policy maker, program manager, researcher, women's' advocate, and a media personnel-----each exclusively resolute in their respective fields. They contrived their professional views and ideas based on the presentations, discussions and group recommendations.

Highlighting media as a key role player through which information must be widely spread out, the panelists discussed about the future directions, mainly spotlighting on IEC and Advocacy. They also supported the idea of a forum on emergency contraception formulated at the workshop by Population Council and appreciated this as an excellent mean of sharing information, views and experiences among professionals of various fields.

The panelists stressed that the goal of IEC on emergency contraception should not only focus on the method but also emphasis on reproductive health awareness and behavioral change issues. They suggested that the target audience should be more specific - so that the wrong audiences (audiences who do not want to continue EC, or those who have less need of EC) are not chosen. They also urged to develop proper service delivery guidelines and facilitate services for dissemination of information among the providers such as, establishing emergency contraception corners in medical colleges, NGO clinics and other MR and family planning clinics. They added that women's group who are involved at the grass-root level should be well informed on the concept emergency contraception since they had better access to the community.

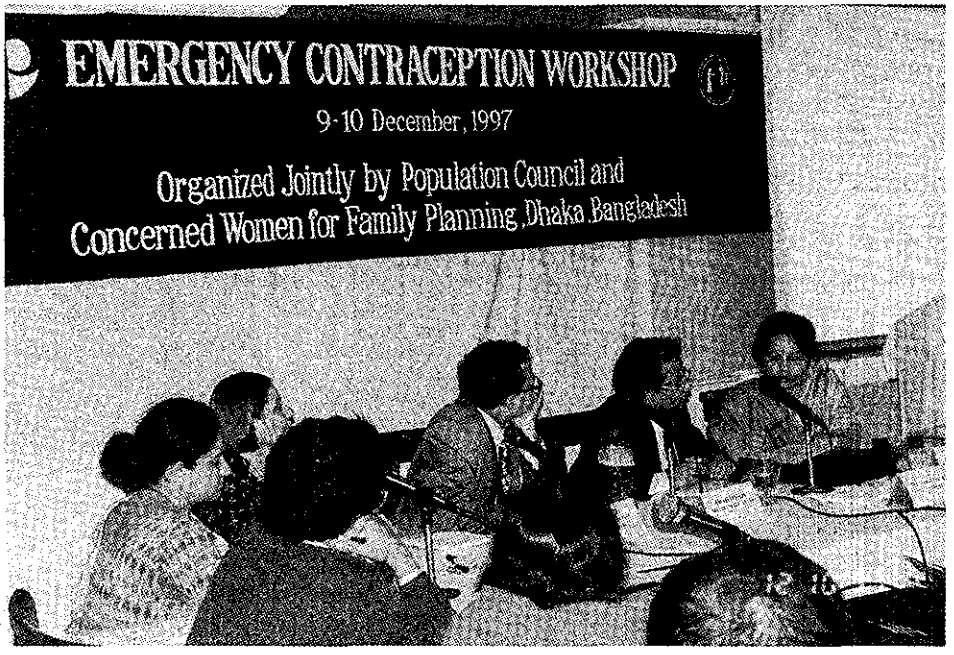
Appreciating the concern of the workshop participants that emergency contraception may have a negative effect on people's sexual behavior, such as, extra-marital, pre-marital or unplanned sex--- the panelists hinted in indiscriminate use of the methods. Henceforth, they recommended that the side effects, contraindications and complications from the use of these methods should be clearly stated hoping that the chance of any sort of misuse will be eliminated.

On the issue of RU-486 as an emergency contraception, they mentioned that though it has been used as a method of EC, it is yet to be a proven one. Henceforth, before accepting RU-486 as an EC, the respected panelists urged for further intense study and research.

They agreed that EC acts as a backup method which could play a key role in the reduction of unwanted abortions and strictly categorized that EC should not be considered, by any chance, as a substitution of the ongoing family planning methods.

In their discussion the learned panel discussants suggested that the issue of EC should be raised in national conferences and urged the policy makers to find out proper ways to categorize it in the existing programs so that people are not misguided. They pointed out that if EC is approved by GoB to use at a wider range, the first task will be to develop a curriculum containing updated and accurate information. The discussants stressed on affordable pricing and easy accessibility of EC materials to all people of different category, irrespective of their differences. They signified circulation of vital information regarding timing, limit and dose of emergency contraceptives through proper media channels.

Finally the panelists congratulated the authority for organizing such an important workshop and wished for more workshops of this kind to be held in various parts of the country which would definitely open a whole new terrestrial sphere on the family planning dominion. They were hopeful that once the method starts, it would have an upward lift.


EMERGENCY CONTRACEPTION WORKSHOP
9-10 December, 1997
Organized Jointly by Population Council and
Concerned Women for Family Planning, Dhaka, Bangladesh

4.4

FORUM ON EMERGENCY CONTRACEPTION

Population Council, Bangladesh proposed a Forum on Emergency Contraception (FEMCON) during the second day of the Emergency Contraception Workshop in the view of bringing people from different fields together to work towards developing programs and activities on Emergency Contraception. The response towards the idea of such a forum was unified by sixteen organizations, both governmental and private sector. The following organizations expressed their interest to be a member of the forum.

1. Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (BIRPERHT)
2. Bangladesh Association for Prevention of Septic Abortion (BAPSA)
3. Bangladesh Center for Communication Programs (BCCP)
4. Bangladesh Women's Health Coalition (BWHC)
5. Bangladesh Nari Progoti Shangha (BNPS)
6. Concerned Women for Family Planning (CWFP)
7. The Daily Star
8. Directorate of Family Planning
9. Family Planning Association of Bangladesh (FPAB)
10. International Center for Diaerrhoeal Disease Research, Bangladesh (ICDDR,B)
11. National Institute of Population, Research and Training (NIPORT)
12. Nari Pokkho
13. Medimpex
14. Padakhep
15. United States Agency for International Development (USAID)
16. United Nations Children's Emergency Fund (UNICEF)
17. Urban Family Health Project, John Snow International (UFHP, JSI)
18. Family Planning Clinical Supervision Team (FPCST)

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APPENDIX

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5.1

EMERGENCY CONTRACEPTION WORKSHOP

VENUE: LaBoheme Restaurant
65 Gulshan Avenue, Gulshan, Dhaka
DATE: 9-10 December, 1997
Organized Jointly by Population Council and Concerned Women for Family Planning, Bangladesh

Day 1, Tuesday, December 9, 1997

9.00-9.30am	Registration
Session I :	**Inaugural Session**
9.30 am-9.35am	Address of Welcome and Workshop Objectives: **Dr. Syeda Nahid Mukith Chowdhury**, National Program Coordinator, Population Council, Bangladesh
9.35am-9.45am	**Ms. Anne Aarnes**, Deputy Mission Director, USAID, Bangladesh
9.45am-10.00am	Experiences from the South and East Asia Region: **Dr. Saroj Pachauri**, Regional Director, Population Council, South and East Asia
10.00am-10.15am	Address by Chairperson: **Director General**, Directorate of Family Planning
10.15am-10.30am	Tea Break
Session II :	**Emergency Contraception: the Concept and Context**
Chairperson:	**Dr. Saroj Pachauri**, Regional Director, Population Council, South and East Asia
10.30am-10.45am	Knowing Each Other
10.45am-11.05am	History, Safety, Efficacy and Global Picture of Emergency Contraception: **Dr. Charlotte Ellertson**, Program Associate, Population Council, New York
11.05am-11.25am	South Asian Experiences on Emergency Contraception: **Dr. N.T. Giang**, Population Council, Vietnam
11.25am-11.40am	Pathfinder International's Experiences On Emergency Contraception: **Dr. Shabnam Shahnaz**, Technical Services Manager, Pathfinder International, Bangladesh
11.40am-12.00am	Advocacy Need and Role of Media: **Ms. Anjali Nayyar**, Communication Specialist, Population Council, India
12.00am-1.00pm	Discussion Session
1.00pm-2.00pm	Lunch Break
Session III :	**Bangladesh Perspective**
Chairperson:	**Dr. Halida H. Akhter**, Director, BIRPERHT, Bangladesh
Special Guest:	**Director General**, Directorate of Health
2.00pm-2.15pm	Emergency Contraception and Male Responsibility: **Dr. A. J. Faisel**, Country Director, AVSC International, Bangladesh
2.15pm-2.30pm	Services Providers Concerns and Considerations: **Prof. T. A. Chowdhury**, President, EOC, Bangladesh

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2.30pm-2.45pm	Providers KAP on Emergency Contraception in Bangladesh: **Dr. Syeda Nahid M. Chowdhury / Dr. Sharif Md. Ismail Hossain**, Population Council, Bangladesh
2.45pm-3.30pm	Discussion Session
3.30pm-4.00pm	Tea Break

Day 2, Wednesday, December 10,1997

Session I :	**Bangladesh Perspective (continued)**
Chairperson:	**Dr. Zahiruddin Ahmed**, Director, MCH, Bangladesh
9.30am-9.45am	Scope of Emergency Contraception in Bangladesh: **Dr. Halida H. Akhter**, Director, BIRPERHT, Bangladesh
9.45am-10.00am	Emergency Contraception Enhancing Women's Choice for Prevention of Unwanted Pregnancy in Bangladesh: **Dr. Yasmin H. Ahmed**, Country Director, Marie Stopes Clinic Society, Bangladesh
10.00am-10.15am	Needs for Emergency Contraception-Experiences from the Grass Roots: **Ms. Mufaweza Khan**, Executive Director, CWFP, Bangladesh
10.15am-10.30am	Tea Break
10.30am-11.15am	Discussion Session
11.15am-1.00pm	**Group Discussion**: Group-I: Viable Choice of ECP Group-II: Service Delivery Issues Group-III: Advocacy and IEC
1.00pm-2.00pm	Lunch Break
Session II :	**Concluding Session**
Chairperson:	Secretary, Ministry of Social Welfare
2.00pm-2.45pm	Group Presentation
2.45pm-3.30pm	Panel Discussion for Future Direction **Dr. Saroj Pachauri**, Regional Director, South and East Asia, Population Council **Dr. Halida H. Akhter**, Director, BIRPERHT, Bangladesh **Dr. Zahiruddin Ahmed**, Director, MCH, Bangladesh **Ms. Asha Mehrin Amin**, Assistant Magazine Editor, the Daily Star **Ms. Nasreen Haque**, Member, Nari Pokkho, Bangladesh
Vote of Thanks:	**Dr. Ubaidur Rob**, Resident Advisor, Population Council, Bangladesh
3.45pm	Tea Break

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